

# Problem drug users' experiences of employment and the benefit system

by Linda Bauld, Gordon Hay, Jennifer McKell  
and Colin Carroll

**Department for Work and Pensions**

**Research Report No 640**

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**Linda Bauld, Gordon Hay, Jennifer McKell and Colin Carroll**

A report of research carried out by the University of Bath and the University of Glasgow on behalf of the Department for Work and Pensions

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# Abbreviations

AFDC	Aid to Families with Dependent Children
BCS	British Crime Survey
CAB	Citizens Advice Bureau
CES	Customised Employment Support
DAT	Drug Action Team
DORIS	Drug Outcomes Research in Scotland
DVT	Deep vein thrombosis
DWP	Department for Work and Pensions
EIU	Effective Intervention Unit
ESA	Employment and Support Allowance
GA	General Assistance
HNC	Higher National Certificate
IB	Incapacity Benefit
IS	Income Support
JSA	Jobseeker's Allowance
MDA	Misuse of Drugs Act
NACRO	National Association for the Care and Resettlement of Offenders
NFFI	New Futures Fund Initiative
NTA	National Treatment Agency

NVQ	National Vocational Qualification
PDU	Problem drug user
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
UKDPC	UK Drug Policy Commission

# Summary

## Introduction

This study was commissioned by the Department for Work and Pensions (DWP) to examine the issues surrounding benefit uptake in England by individuals who use illicit drugs, in particular heroin and crack cocaine. Individuals who take these drugs are termed 'problem drug users' (PDUs). In addressing these issues, the study also explores the wider context of education, training and employment for drug users as well as the role of treatment.

This report has two key elements: a review of the literature on drug use and benefit uptake and a qualitative component that included face-to-face semi-structured interviews with 75 drug users and ten professionals who work with drug users to explore specific issues in detail. The research was carried out by a team from the Centre for Drug Misuse Research at the University of Glasgow and the Centre for the Analysis of Social Policy in the Department of Social and Policy Sciences at the University of Bath.

## Literature review

### **The profile of problem drug users**

It is apparent from the literature that the needs and circumstances of PDUs are varied. Overall, they are a marginalised group, many of whom (although not all) have experienced disadvantage from an early age. The UK and European literature on problem drug use suggests that most PDUs are male and that this type of drug use is most prevalent among individuals in their 20s and 30s (March *et al.*, 2006; Payne-James *et al.*, 2005; Puigdollers *et al.*, 2004). Problems with housing and homelessness are common in studies of drug-using populations (Kemp *et al.*, 2006) as are low levels of educational attainment (Puigdollers *et al.*, 2004; Luck *et al.*, 2004). Mental and physical health problems affect a significant proportion of PDUs. The literature we reviewed identified a number of concurrent physical health problems, particularly among long-term drug users (Hser *et al.*, 2004), including higher rates of hepatitis C, HIV/AIDS and physical impairments that can

affect PDUs' ability to complete everyday tasks and therefore, to work (Neale, 2001; Kemp and Neale, 2005; March *et al.*, 2006; Payne-James *et al.*, 2005). The prevalence of a range of mental health problems amongst PDUs is also well documented (Graham *et al.*, 2001, Johnson *et al.*, 2002).

### **PDUs and the benefits system**

Research has found that PDUs account for almost seven per cent of the working age population on benefits in England, while they make up only one per cent of the working age population overall (Hay and Bauld, 2008). However, various barriers to claiming benefits were also identified. Henderson and colleagues in the USA interviewed welfare agency workers and found that, in their view, adults with substance misuse problems require more intensive, personalised attention than most workers were able to provide (Henderson *et al.*, 2006). PDUs also commonly reported feeling stigmatised by welfare workers (Luck *et al.*, 2004).

### **PDUs and employment**

Studies have found that users of 'hard' drugs such as heroin and crack cocaine are significantly less likely to be in employment than other adults of working age (MacDonald and Pudney, 2001, 2002). Research has also found that duration of unemployment is associated with the number of drugs an individual has used (Plant and Plant, 1986).

Studies suggest that PDUs face considerable challenges in making the transition to work. For example, Sutton and colleagues conducted a review of the literature examining barriers to employment for adults with drug and alcohol problems (Sutton *et al.*, 2004). They identified six major areas of disadvantage that acted as barriers to work including: lack of education and skills; health; social disadvantage; provision of support services; engaging with employers and support professionals; and dealing with stigma. Recent research conducted by the UK Drug Policy Commission (UKDPC) has examined similar issues (UKDPC, 2008).

In addition to the main barriers highlighted by Sutton and colleagues, we also found that mental health problems and involvement in crime were significant issues. The literature reviewed highlighted that mental health problems can make returning to the labour market difficult or impossible for adults with substance misuse problems (Zabkiewicz and Schmidt, 2007; Marwaha *et al.*, 2007). The links between criminal behaviour and drug use are clear from the literature, as are the consequences in terms of employers' unwillingness to take on those with criminal records (Kemp *et al.*, 2004; Payne-James *et al.*, 2005; UKDPC, 2008).

## **Welfare reform**

We touched indirectly on the issue of welfare reform in this study; in the context of the changes introduced in the 2009 Welfare Reform Act following the green paper *No one written off: reforming welfare to reward responsibility* (DWP, 2008). One element of these reforms, the Welfare Reform Drug Recovery Pilots, is being piloted in five areas across England from October 2010. It involves a new Additional Support programme which, on a voluntary basis, will provide integrated and personalised support for Jobseeker's Allowance (JSA) and Employment and Support Allowance (ESA) claimants who are undergoing drug treatment. A Treatment Allowance for PDUs who are in treatment, in place of their ESA or JSA, will be payable on a voluntary basis to the individual as long as they maintain their treatment and engage with the Additional Support programme. In addition, some of the normal conditions of entitlement for benefit will be removed in order to allow drug users the time and space to focus on their recovery. For example, this will mean that those on JSA will not be required to sign on or show that they are actively seeking work. PDUs who are in receipt of JSA and ESA and not ready to go into treatment will be required to attend a Substance Related Assessment with a drug treatment adviser and then a Treatment Awareness Programme for six weeks.

Other countries have introduced similar changes in the past, and a literature on welfare reform and its impact on drug users does exist, primarily from the USA. American studies on the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) reforms of the mid-1990s, although not directly comparable, do suggest that welfare recipients who accessed treatment were more likely to find employment, that clients in government-funded treatment did reduce their drug use, and that fears regarding longer-term, negative outcomes from introducing these reforms were largely unfounded (Montoya and Atkinson, 2002). However, in the short term at least, drug users in the USA who lost entitlement to benefits through not complying with the new regime were more likely to return to drug-related crime to fund their drug use (Montoya and Atkinson, 2002; Swartz *et al.*, 2004).

## **Client interview findings**

### **Client characteristics**

The majority of respondents were in early middle age, however, this was one of only a few characteristics that they had in common. In other respects the sample was quite diverse: some respondents had no caring responsibilities or limited family connections, others were responsible for young children or had the support of an extended family. Similarly, some had stable living arrangements with no pressing financial issues, whilst others reported poor and/or temporary housing and problems covering basic expenses. The most substantial differences amongst respondents, however, related to their experiences in childhood and young

adulthood. For some, drug use was just another part of an already troubled life, often involving traumatic events or a compromised childhood. However, others had a more stable upbringing and found themselves experimenting with drugs for recreational purposes.

### **Education**

Respondents' accounts of their schooling tended to be fairly negative. There were many accounts of school expulsion, as well as a high prevalence of truancy. Interviewees also spoke of encountering bullying and dealing with dyslexia. It is, therefore, perhaps no surprise that most respondents left school with few qualifications. Such poor school experience, however, didn't deter some respondents from taking up training following school, with several reporting vocational qualifications. Despite the success of some respondents, though, most remained low qualified, and lacking many of the skills sought by employers.

### **Employment history**

It was uncommon for respondents to be in paid legal employment at the time of interviewing. Many, however, were involved in volunteering, often situated in drug and alcohol services. Respondents viewed volunteering as very beneficial, recognising the opportunities it offered for moving back into employment or simply as part of their recovery. Most had worked at some point in the past, but whilst some had enjoyed long periods in the same job or industry, others had experienced employment on a short-term and infrequent basis. There were also significant differences in the skill-set of respondents and therefore, the types of jobs they achieved. Certain interviewees had advanced work-related knowledge and skills which meant they had experienced responsible and challenging employment. In contrast, other respondents possessed few vocational skills which confined them to unskilled jobs. Finally, the mixture of experience exhibited by respondents was also demonstrated in terms of post-school employment. Some interviewees encountered no problems in obtaining employment following leaving school, but others faced long periods of unemployment.

### **Drug use history**

Many of the interviewees had a long history of drug misuse, with most beginning during their teens whilst still at school. These respondents typically began smoking cannabis with friends, moving on to harder drugs such as heroin and crack cocaine in later years. Other drugs used by respondents included cocaine, amphetamines, ecstasy and LSD. For some, their drug use was complicated by using drugs intravenously or accompanying alcohol use. Most respondents reported the impact of certain crises such as the threat of losing their home as causing them to realise that their drug use had become problematic. In terms of treatment, many respondents had extensive experience of accessing support to address their drug use, with some reporting relapse following long periods of recovery.

## **Claiming and receiving benefit**

All of the respondents were either currently in receipt of benefits or had received them in the past. Some received Incapacity Benefit (IB) (or ESA) due to poor mental or physical health and addiction, but others were receiving JSA. Despite being on similar benefits interviewees' experiences of the benefit system were varied. Some respondents described applying for benefits as straightforward and Jobcentre Plus staff as positive and helpful. Others had had more problematic experiences and described in detail the problems they encountered during their medical examinations and capability assessments. Furthermore, some interviewees provided examples of administrative mistakes and delays and highlighted how these had affected their lives and their efforts to make the transition from benefits to work.

## **Barriers to benefit uptake**

A number of barriers to claiming benefits were highlighted during the interviews. These included a lack of knowledge regarding benefit entitlement and a lack of easily available advice on this issue; difficulties with requirements to fill out application forms and attend appointments; and problems with the facilities used by Jobcentre Plus to handle client enquiries and consultations. Further barriers encountered related to respondents' relationship with staff working within Jobcentre Plus. Some respondents described feeling stigmatised by workers, whilst others said they felt they had to behave in a certain way in order to receive help.

## **Looking for employment through Jobcentre Plus**

Some respondents encountered problems in matching their employment expectations to the type of jobs promoted by Jobcentre Plus, and felt that the jobs advertised lacked relevance to their particular skills, or lacked prospects. Others expressed negative views about Jobcentre Plus staff's understanding of their circumstances in relation to their ability to work, with particular reference to their methadone prescriptions. Respondents felt that Jobcentre Plus could do more to help customers like them find employment, including providing more encouragement to apply for jobs, ensuring they follow up opportunities and offering more gradual paths back into employment.

## **Barriers to employment**

Drug users face a variety of obstacles with regard to looking for employment, of which most are deeply entrenched. These include poor self-confidence and mental health problems, physical health problems, a lack of education, training and skills, ongoing drug use, receiving treatment whilst working and stigmatisation by employers, amongst other barriers. Many of the obstacles highlighted, such as a lack of education and training and ongoing drug use, have the scope to be improved by the individuals concerned providing they have the support and motivation to devote time and effort to them. However, other barriers may prove harder to overcome and require broader societal change. The reported reluctance



on the part of employers to take on individuals with a history of drug misuse, or with criminal convictions, is an obstacle that is rooted in social attitudes and therefore much more difficult to alter.

### **Informal economy**

Interview respondents' accounts provide compelling evidence of the link between drug misuse and crime, as established in the literature review and by other studies that have examined the experiences of PDUs. Respondents commonly admitted to involvement in shoplifting, burglary, drug-dealing and fraud as a means of obtaining money for drugs. In some instances respondents who had been involved in drug-dealing spoke of being motivated to sell drugs because they had easy access to them. As a result of such crimes, many interviewees had spent time in prison, with some having spent most of their adult life moving in and out of prison. Involvement in the informal economy was common amongst respondents, with most admitting having done cash-in-hand work. This, as well as some interviewees' involvement in prostitution, further highlights the barriers that drug users face in finding legitimate employment.

### **Future aspirations**

Almost all interviewees viewed becoming drug-free as a higher priority than coming off benefits and getting a job. For many, this involved coming off a methadone prescription. Conversely, however, some wanted to start taking methadone precisely so they would be able move back into employment, illustrating just how personal ideas about what constitutes recovery are. Many interviewees worried that they would not be able to cope with the pressures and stress involved in working life and feared a relapse as a result of these. Interviewees generally saw voluntary work, often with drug treatment services, as a first step towards paid employment. This represents a way for them to test out their ability to work, and also to give something back to their community and help support others in a similar position.

## **Professional interview findings**

### **Characteristics of PDUs**

Professionals described PDUs in their areas as a marginalised group who experienced stigma and had complex needs, including mental and physical health, employment, housing and family problems. They felt that drug use both exacerbated pre-existing problems and led to new ones. Views were divided about whether PDUs are generally willing to disclose details of their drug use to professionals, however there was consensus about the fact that they are at strong risk of stigma and discrimination.

## **The benefit system**

Views were mixed about the role of the benefit system in drug users' lives. Some professionals felt that the system provided a perverse incentive for PDUs to appear as disabled as possible in order to gain access to a higher level of benefit, whilst others emphasised the importance of benefits as a safety net that enables drug users to survive. As such, many described benefits as a central component of recovery from drug use. The most common benefits for the interviewees' clients to be receiving were Income Support (IS) and IB, as well as JSA. Various barriers to claiming benefits were identified, some of which were the same as those identified by the PDUs themselves earlier in the report, such as problems with filling out forms and attending appointments. Others were similar but expressed in a different way, such as the mismatch between the behaviour of their clients and Jobcentre Plus staff's expectations of them that the professionals described. They emphasised the importance of advocacy by and support from facilitators in helping drug users to negotiate the benefit system.

## **Treatment**

Treatment services were available to PDUs in all of the case study areas, however, interviewees acknowledged that a drug users' decision to enter treatment is a very personal one which is hard for them to influence. They also identified waiting times as a problem for those who decide they do want treatment. Paths to recovery were described as long and complex, with most clients going through treatment multiple times. They felt that whilst returning to work was a more long-term aim for most clients, training and voluntary work is a good stepping stone to employment for those who are ready for it.

## **Employment**

The vast majority of drug users that the professionals encountered were unemployed. Where they were employed legitimately they tended to be in low paid and short-term jobs. The professionals emphasised the positive impact that employment can have on PDUs' lives, however, they acknowledged that the transition from benefits to employment is a challenging one for this group and mentioned mental health issues, medication, employer attitudes and time out of the labour market as some of the barriers that they face. The main facilitators to employment that the professionals mentioned included advocacy, access to training and voluntary work, and opportunities provided by supportive employers.

## **Partnership working**

Knowledge of the benefit system was limited amongst the professionals interviewed, as were any formal links with Jobcentre Plus or DWP. However, they were keen to improve these links through training of staff in both drug agencies and Jobcentre Plus, specialist staff being placed in the partner agency, and co-location.

## Conclusion

Our findings illustrate the complex needs of PDUs and some of the challenges they face in their everyday lives. All the PDUs in our study had experience of the benefit system and had accessed different forms of benefits, primarily IS, JSA and IB. While very few were in paid employment at the time of the study almost all aspired to move back into some form of work in the future and described some of the forms of support, including access to training and voluntary work, that would assist in that process.

This study highlights the need for greater integration between drug treatment services, the social security system, employment services and employers. This, combined with wider availability of support to PDUs, will improve outcomes for this group.

# 1 Introduction

This study was commissioned by the Department for Work and Pensions (DWP) to examine the issues surrounding benefit uptake by individuals who use illicit drugs. This report has two key elements; a review of the literature on drug use and benefit uptake and a qualitative component that included semi-structured interviews with drug users and professionals who work with drug users to explore specific issues in detail. The research was carried out by a team from the Centre for Drug Misuse Research at the University of Glasgow and the Centre for the Analysis of Social Policy in the Department of Social and Policy Sciences at the University of Bath.

There are a range of substances that can impact on an individual's ability to sustain employment and thus affect whether or not they need to access state benefits. There are health consequences of alcohol or tobacco use that can impact on employment, and excessive use of alcohol can lead to increased absence from work or health and safety related issues. In terms of illicit substances, there is a range of drugs used by the working age population in the United Kingdom, with the 2007/08 British Crime Survey (Hoare and Flatley, 2008) suggesting that just under three million people aged 16 to 59 in England and Wales had used illicit drugs in the past year, with 1.7 million using illicit drugs in the past month. The most commonly used drug was cannabis, with approximately 2.3 million people estimated to be using it in the preceding year. Clearly not all of the three million people using drugs are unemployed or in receipt of DWP benefits.

There is, however, a particular focus on the drugs that can cause significant problems for the individual and society. The Home Office has commissioned research to estimate the number of people who use opiates (such as heroin) and/or crack cocaine (Hay *et al.*, 2008). Repeated analyses covering the three year periods of 2004/05, 2005/06 and 2006/07 suggest that the estimated number of opiate and/or crack cocaine users, or problem drug users (PDUs) in England is around a third of a million.

In a previous study carried out by the same research team, initial estimates of the number of opiate and/or crack cocaine users in receipt of state benefits in 2005/06 were produced for the DWP (Hay and Bauld, 2008). In total it was estimated that

there were approximately 66,000 PDUs accessing Jobseeker's Allowance (JSA) and approximately 87,000 PDUs accessing Incapacity Benefit (IB) in England. A larger number of PDUs (146,000) were estimated to be accessing Income Support (IS). Although it is estimated that approximately 1.1 per cent of the working age population in England are PDUs, 8.2 per cent of JSA claimants and 4.4 per cent of IB claimants are estimated to be PDUs.

Our previous study raised a number of questions. In particular, information was lacking on how and why PDUs access benefits. Information was also not available on how they come to be receiving particular benefits, and whether the benefits they are on accurately reflect their situation (eg. whether PDUs on JSA are all able to work or actively seek work), what benefits they have previously been on, and who has influenced them in applying for benefits or switching from one benefit to another (e.g. their GP, drug worker, friends, etc). Limited information was also available on the pathway that PDUs take between accessing benefits, receiving treatment for drug misuse and moving into employment. Finally, our previous study also encouraged us, and the DWP as research funder, to consider the wider context of the relationship between problem drug use and other groups of socially excluded adults, such as care leavers, offenders under probation supervision and adults with secondary mental health difficulties.

## 1.1 Aims

The aims of this study were to explore in depth the issue of benefit uptake amongst adults who use, or have recently used, heroin or crack cocaine in England. In aiming to address this question, the study also aimed to explore the wider context of education, training and employment for drug users as well as the role of treatment.

The study aims were addressed through reviewing relevant literature and interviewing PDUs and professionals in a number of case study areas in England. Our approach to the study and the methods we used are described in the next section. We then summarise findings from the literature review, explore the views of drug users in some detail, and outline findings from interviews with professionals in the case study sites. This is followed by a discussion section that links our interview findings with key themes from the literature and a conclusion that highlights key implications for policy.

## 1.2 Methods

This study was composed of two parts: it began with an extensive review of relevant literature, drawing on systematic review methodology. It also involved semi-structured interviews with two groups of adults in the five case study areas – PDUs, and a small number of professionals who work with drug-using clients. This section of the report describes our approach to the literature review and to the interviews.

### 1.2.1 Literature review methods

The literature review component of this study was informed by systematic review methodology. However, it does not constitute a full systematic review due to the wide range of relevant study designs identified and the short time scale for the work, which ruled out full critical appraisal, data extraction and meta-analysis of studies. The approach to the review is systematic in that relevant literature was searched and screened rigorously, building on previous reviews conducted for the National Institute of Health and Clinical Excellence by members of the research team (Bauld *et al.*, 2007; Bell *et al.*, 2007; Richardson *et al.*, 2008; Bauld *et al.*, 2009).

The approach taken was to identify a search strategy, using key words, and to apply this strategy to a range of relevant databases and websites. The key words used are included in Box 1.

**Box 1: Search Strategy**

Drug use  
Drug users  
Problematic drug use/users  
Drug misuse  
Drugs  
+  
Benefits  
Welfare  
Unemployment  
Social assistance  
Social insurance  
+  
Mental health  
Care leavers  
Offenders/offending  
Crime/criminal

The following databases were searched for references from 1980 onwards using the strategy: Medline, Social Science Citation Index and Science Citation Index (Web of Science), Psychinfo, Social Care Online, Drugscope, Index of Theses. A number of relevant websites were also searched to identify relevant grey literature.

Due to the broad nature of the search strategy over 15,000 relevant references were initially identified and following the removal of a large number of duplicates, the remaining references were then screened by two members of the research team on the basis of title only, to identify the extent to which the publications were relevant to the terms of the review. Following screening by title, abstracts of

the remaining sources were obtained and a further screening stage took place. The result was that 84 publications, consisting primarily of peer-reviewed journal articles, were identified for review. One of these publications was a literature review previously conducted for the DWP by Sutton and colleagues (Sutton *et al.*, 2004). This review focused on drug and alcohol use as barriers to employment and key findings are summarised in the employment section of the literature review.

These publications were reviewed by two members of the research team and key findings extracted and summarised according to the themes outlined above. A narrative synthesis of the studies was then drafted for each theme. In a number of cases, an article was relevant to more than one theme and so may be cited more than once in the review below.

### *Limitations of literature review*

This review faced a number of limitations and these should be kept in mind when interpreting the evidence presented. The first is that the evidence is likely to be of mixed quality. In a full systematic review, the included studies would have been critically appraised for their methodological rigour, data extracted and organised into evidence tables. This process was not possible given the timeframe for the study and the fact that the research identified contained many study types that would have been time-consuming to individually classify and critique. As a result, this review should be regarded **as a summary of key points from available literature** rather than one that is limited to only the most robust evidence.

Secondly, during the screening stage of the review we prioritised UK studies in order to identify the most relevant evidence. However, for a number of key themes (such as the impact of welfare reform on drug users) there were no UK studies. For other themes only one or two UK studies emerged. As a result we have included selected international evidence here, in most cases American studies. This limits the applicability of the review to the UK context. It is also worth noting that a highly relevant report *Getting Problem Drug Users (Back) into Employment*, was published by the UK Drug Policy Commission (UKDPC) in December 2008, after the literature search had been conducted (UKDPC, 2008). It was not included in our review but we do cross-refer to this work in the discussion section of our report, as some of its findings are similar to ours.

Third, much of the literature included is not limited to users of heroin or crack cocaine. In a small number of cases studies focus on users of a single drug, more commonly on users of any illegal drug, and in many cases on substance misuse in general. In studies where both alcohol and drug users were included, we examined the article to identify if any results for drug users were reported separately, and where this was the case we have focused on these. However, in most cases findings were not disaggregated, and therefore some caution should be used when assuming that findings from these studies are directly relevant to PDUs.

Finally, given the breadth of literature reviewed here, the review includes only

a limited amount of information about each included study. It focuses on key messages or lessons. For more information on the research included, readers should consult the original references that are listed at the end of this report.

### **1.2.2 Interview methods**

The five case study sites for the study were selected in consultation with colleagues from the DWP and the Drug Action Teams (DATs) in the areas. The case study sites were chosen to cover different types of location in England, including urban and semi-rural areas, and included communities where drug misuse was identified as a local problem.

One member of the team made contact with the DAT in each area and explained the research. An information sheet about the study and the interview process was sent to each DAT at the start of the study. Following receipt, any questions about the study were answered and all five areas agreed to take part. DAT staff agreed that they would identify and approach clients who were currently or had recently been in treatment and help to arrange research team visits, as well as identify a small number of local professionals who could be interviewed.

Before any fieldwork began, another member of the research team conducted telephone interviews with two senior professionals in national agencies, including a colleague in the DWP and another in the National Treatment Agency (NTA), in order to obtain relevant contextual material to inform the research. These interviews focused on recent policy changes (in particular, the welfare reform green paper and its implications for PDUs). The interviews were not tape recorded nor transcribed, but written notes were taken and these informed the topic guides for the case study visits and the writing up of this final report.

Three members of the research team conducted the fieldwork in the five case study sites. Visits commenced in the third week of February 2009 and fieldwork was completed by the end of March.

#### *Interviews with drug users*

The research team accessed PDUs in each of the five case study areas through DAT staff, who were in most cases staff with a user engagement remit. DAT staff introduced the study to clients. They also scheduled the interviews for the research team. When the researchers arrived, interviews were conducted in each area during a two- to three-day period. At the start of each interview the researcher explained the study to the interviewee, provided an information sheet and sought written consent. The interview then proceeded using a semi-structured topic guide that was designed to include key issues from the literature and recent policy and was agreed in advance with colleagues at the DWP. Individuals who participated in an interview were provided with a small payment for their time, with interviews lasting between 15 minutes and one hour.



Interviews were conducted with 75 adults who were current or recent users of drug treatment services<sup>1</sup>. In each area between 12 and 15 PDUs were interviewed, with the exception of one DAT area where 20 individuals participated in the study. Two-thirds of the interviewees were male (54 people), reflecting the profile of PDUs in England. A smaller proportion of interviewees (21 people) were women. The average age of those interviewed was 37 years old.

### *Interviews with professionals*

A small number of professionals (ten people) were interviewed as part of the study. Two professionals were interviewed in each case study site with the exception of two areas where, respectively, one professional and three professionals were interviewed. The professionals were all individuals who worked with drug users, usually in a supportive capacity and often with a remit for user engagement or helping people access benefits, housing, educational opportunities or training. For example, the sample included a number of client advocates who worked either within the DAT or for voluntary sector organisations, community support workers within the local service user forum, an aftercare worker within the DAT, a manager of a voluntary agency that specialised in moving PDUs into training and employment, a welfare rights officer and, in one area, a GP who had a national enhanced service for drugs. We were unable to interview DWP/Jobcentre Plus staff for the study at the time of the research. Most of the interviews with professionals were conducted face to face, with four completed by phone. The interviews lasted between 35 minutes and one hour.

Because of the small number of professionals interviewed and the importance of confidentiality and anonymity in a study of this kind, we do not identify the interviewees either by name, occupation or area in the findings section. Instead, we outline key themes and direct quotes without attributing these to particular interviewees. This approach means that any potential differences between case study areas may be difficult to distinguish. However, where these differences were apparent we have highlighted them in the text while retaining the anonymity of our interviewees. It also means that it may be difficult to identify where the views of interviewees have been shaped or influenced by their professional background. However, as this study did not set out to represent the views of any particular group of professionals in relation to drug misuse and the benefits system, we believe that these limitations do not undermine the value of the information provided.

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<sup>1</sup> A very small proportion of the clients recruited through DATs disclosed during interview that their addiction was to alcohol or drugs other than opiates or crack cocaine.

### *Analysis*

All interviews were tape recorded using a digital recorder and transcribed following the completion of fieldwork. These transcripts were then analysed using the framework approach, which is a qualitative analysis approach commonly employed in applied policy research (Ritchie and Lewis, 2003). The same process of analysis was undertaken for both the drug user and professional interviews.

Analysis began with members of the research team reading through the transcripts. The PDU transcripts were initially divided by case study area due to the large number of interviews. At least two members of the research team, assisted by other staff in the Centre for Drug Misuse at the University of Glasgow, read through the transcripts for each area. On the basis of this initial reading, a number of key themes were identified. These themes then served as the basis for developing a series of frameworks for each theme. A re-reading of the transcripts produced sub-themes which were then added to the framework. This process began with a sample of transcripts for each area (on average five) and then the remainder of transcripts were re-read to ensure that no new themes had been missed. A third member of the research team checked the resulting framework documents which organised key quotes from the interviews by theme and sub-theme. Finally, a resource document was produced that included a narrative that explored the main themes and sub-themes with key quotes – this served as the basis for drafting the findings section for the PDUs' and the professionals' interviews, with one member of the research team taking primary responsibility for the PDUs findings section and another team member drafting the professionals findings section. Draft findings were reviewed by other team members to ensure that the reporting was comprehensive and accurate.



## 2 Literature review

There is fairly extensive UK and international literature on the causes and consequences of illegal drug use, including heroin and crack cocaine use. Some of this literature is relevant to the current study, in particular research that has explored links between the benefit system and drug misuse and routes in and out of benefits for drug users. However, given that the reasons that individuals take up benefits in the first place are complex, it was agreed with the Department for Work and Pensions (DWP) that the literature review element of this study would take a broader approach than merely focusing on drug use and the social security system. Instead, we reviewed key literature on a range of themes including:

- the characteristics of problem drug users (PDUs);
- mental health problems and drug use;
- crime and drug misuse;
- the treatment of drug misuse;
- the relationship between drug use, unemployment and employment;
- the employability of drug users;
- the interaction of drug users with the benefit system;
- welfare reform and drug misuse.

By examining this wider literature, this review aims to inform current policy and practice aiming to address some of the reasons why individuals end up on benefits in the first place (such as mental health issues) and to investigate treatment, training, and in some cases, employment opportunities.

### 2.1 Characteristics of problem drug users

A number of studies in the UK and overseas, most notably surveys, have described the characteristics of individuals who use drugs such as heroin and crack cocaine. Findings from these studies are summarised here, focusing initially on basic

demographic characteristics, followed by physical health problems experienced by drug users, problems accessing health care, homelessness and concluding with a brief section on the links between the care system and drug misuse.

### **2.1.1 Demographic characteristics**

Men are more likely than women to become PDUs. In three European studies, all of which looked at the characteristics of PDUs, men made up more than two-thirds of the sample in each (March *et al.*, 2006; Payne-James *et al.*, 2005; Puigdollers *et al.*, 2004). Drug use can occur at any age, but the same three studies found that the mean age of study participants was between 28 and 31.

Other studies have described the educational attainment of PDUs. Levels of education among PDUs are mixed, and assumptions of low educational attainment within this group are not always correct. One Spanish study found that 75 per cent of their sample only had an educational level of primary school or lower and another found that two-fifths of their sample of drug-using women had dropped out of high school (Puigdollers *et al.*, 2004, Luck *et al.*, 2004). However, a third study found that within a sample consisting of employed and unemployed heroin users, almost two-thirds of participants had high school qualifications (Koo *et al.*, 2007)

Sources of income amongst drug users have also been described in a number of studies. Research has shown that PDUs can be employed, but it is also known that other major sources of income for this group include social security payments, illegal activities and financial support from family and friends. In a study that looked at drug treatment outcomes in Scotland, Kemp and Neale found that only four per cent of people entering drug treatment were in paid employment, with 13 per cent having held a job in the last six months (Kemp and Neale, 2005). They also found that 95 per cent of participants had received social security benefits in the last six months. This study also provided evidence of illegal activity as a source of income with the finding that two-thirds of participants had sold drugs, and nearly half had been involved in burglary or theft in the six months leading up to interview.

Another study, which looked at the issue of income sources, was one that compared the 'income generation activities' of crack users to those of other drug users in New York (Cross *et al.*, 2001:191). In this study, the main hypothesis was that people who use crack on a frequent basis tend to be involved in different income generation activities compared to heavy users of heroin or cocaine and also PDUs who use less often (Cross *et al.*, 2001). Analysing data from 600 participants, the authors concluded that those who use crack on a frequent basis were more likely to be involved in burglary, con tricks, stealing and prostitution than frequent heroin or cocaine users. The issue of crime, including income from crime, and drug misuse is described in more detail later in this review.

### 2.1.2 Physical health problems

PDUs can encounter long-lasting and life-limiting physical health problems as a result of their drug use. A longitudinal study that began with the admission of 542 male heroin addicts to a drug treatment program for offenders in California between 1962 and 1964 found evidence of negative health impacts from long-term heroin use (Hser *et al.*, 2001). After the initial sweep, participants were followed up a further three times, with the most recent wave of interviews taking place between 1996 and 1997. At the time of these interviews, 284 participants had died, leaving 242 participants in the sample. To examine the effects of drug use upon physical health, the remaining participants were divided into two groups; one consisting of those that had been abstinent for five years or less and another including those who were still using heroin. The researchers found that the two groups were indistinguishable in terms of rates of hepatitis, HIV or sexually transmitted disease, but those continuing to use heroin were more likely to experience disability or any physical impairment that prevented or undermined employment (Hser *et al.*, 2001).

As picked up in the previous study, injecting drug users are at risk of contracting hepatitis and HIV, largely through the sharing of hypodermic needles (Neale, 2001). Edlin reported that injecting drug users make up the majority of people with hepatitis C in the USA (Edlin, 2002). In Europe, two separate studies have looked into the extent of such illnesses in their study samples. As mentioned above, March and colleagues investigated the characteristics of drug users in ten European cities and found that 45.9 per cent of their sample had hepatitis C (March *et al.*, 2006). In another study of drug users in police custody, they found that 20 per cent of participants had hepatitis C, six per cent had hepatitis B and almost four per cent were HIV positive (Payne-James *et al.*, 2005).

Kemp and Neale also highlight the debilitating effects of drug use in their analysis of drug treatment outcomes in Scotland (Kemp and Neale, 2005). Through consideration of participants' ability to work, they discovered that many struggled with everyday tasks. This was shown by the fact that almost half the sample were '*limited in climbing several flights of stairs*'; a third were '*limited a lot or a little in walking over a mile*' and more than a third had expressed how pain had '*interfered with their normal work*' (Kemp and Neale, 2005:35). Moreover, a Norwegian study found that the 'health-related quality of life' of injecting drug users was inferior to that of the general population of Norway (Dalgard *et al.*, 2004:74).

### 2.1.3 Problems accessing health care

The physical health problems that PDUs face can be compounded by difficulties accessing health care services. A study of drug users' perceptions of GP services, set up in London, recruited 180 drug users registered at five agencies, including a GP service with special interest in drug treatment (Hindler *et al.*, 1996). Although the majority of participants were registered with a GP, the

researchers found that rather than registering with a GP in their area, 42 per cent of participants preferred to register with a GP they felt would treat them. Nevertheless, participants reported that half the GPs they had seen had not prescribed substitute drugs, with the result that 20 per cent of participants were not receiving any substitute prescription. Furthermore, just under two-thirds of those participants attending all services, apart from the specialist GP service, said that they felt that their GP '*held negative or neutral views about them*' (Hindler *et al.*, 1996:149).

American research has also explored barriers to health care, although differences in health care availability in the USA compared with the UK mean that findings are not directly applicable to the UK context. McCoy and colleagues compared barriers to accessing health care among drug users, injecting drug users and non-drug users in Florida (McCoy *et al.*, 2001). The research found that drug-using participants were most likely to feel that they did not need treatment or to put off treatment (McCoy *et al.*, 2001). To explain this response, the authors highlighted the fact that drug users were more likely to express the opinion that health care would not work for them. Thus, as in the British study, some drug users have little confidence in the health care available to them.

Drug users in the UK have also been shown to face multiple problems in relation to accessing health care. In a qualitative study in the UK involving interviews with injecting drug users, Neale and colleagues found that participants had encountered various barriers (Neale *et al.*, 2008). These included: keeping up to date with appointments; travel issues; limitations associated with poor health; fears regarding the attitudes of professionals and also problems receiving the necessary support. Researchers found that experience of such barriers were mediated by individual client circumstances; how many times clients required access to services and individual professionals' approach to care (Neale *et al.*, 2008).

#### **2.1.4 Homelessness**

Homelessness can be a significant problem amongst drug users. In a study that looked at the characteristics of drug users entering treatment in Scotland, involving two interviews over a period of eight months, it was found that over a third of participants (36 per cent) '*were homeless at either or both interviews*' (Kemp *et al.*, 2006:319). Furthermore, March and colleagues, in their study of drug user's characteristics in European cities found that 14.2 per cent of their sample ( $n = 1,879$ ) were homeless. Similarly, evidence of the links between drug use and housing problems were highlighted by Phinney and colleagues in their study of housing issues among welfare recipients in the USA. The researchers found that drug use, excluding use of cannabis or having no high school education, were linked to eviction and homelessness (Phinney *et al.*, 2007). In terms of risk factors for homelessness among drug users, research has shown that injecting drug use carries a higher risk of homelessness. (Kemp *et al.*, 2006; March *et al.*, 2006) Apart from this, however, Kemp and colleagues also found that drug users tend to share the same risk factors for homelessness with non-drug users, including family problems and poor health (Kemp *et al.*, 2006).

### 2.1.5 Care leavers

Drug misuse is more common amongst individuals who have been in the care system as children than in the general population. Although the literature on this subject is limited, a number of studies that have been conducted with drug users or with care leavers have highlighted the links between the two.

Substance misuse, including, in some cases, illegal drug use, amongst those in care commonly begins in adolescence. In the late 1990s, the Home Office commissioned a review of literature on substance misuse amongst looked after and accommodated young people (Ward, 1998). The review included studies that compared the incidence of substance misuse amongst those in care with other young people, and concluded that looked after young people's substance use is higher than the general population. The review highlighted that substance use amongst this group of young people was regarded as 'recreational' but emphasised that the level of use identified in studies, combined with other risk factors, meant that young people using drugs and alcohol while in care were more likely to become involved in problematic use later in life (Ward, 1998).

Since this review was completed, other studies in the UK and overseas have continued to explore alcohol and drug use amongst those in the care system and after leaving care. A recent American study compared a nationally representative sample of adolescents in the US with those who had a history of foster care placement (Pilowsky *et al.*, 2006). The study compared the incidence of substance misuse and also of psychiatric symptoms in the past year between adolescents who had been in foster care compared with those who had not. In relation to substance misuse, the study found that young people who had been in foster care were five times more likely to have received a '*drug dependence diagnosis*' in the past year than other young people. They also found much higher incidence of psychiatric symptoms, including having attempted suicide, amongst those who had been in foster care. This underlines the interacting nature of some of the risk factors that contribute to drug misuse including mental health issues which we explore in a later section of this literature review.

## 2.2 Mental health and drug misuse

There are a number of links between drug misuse and mental health problems and some of these are explored in the studies reviewed here. Here we summarise key findings relating to: the prevalence and nature of mental health problems amongst PDUs; treatment for drug misuse and mental health problems; and mental health problems and employment.



### 2.2.1 Prevalence and nature of mental health problems among drug users

'Dual diagnosis' is a term which refers to a situation where an individual who exhibits problem drug or alcohol use also suffers from mental health problems. According to the literature reviewed here, the extent to which drug and alcohol using populations also experience mental health problems varies, though the proportion affected tends to be substantial. In a study of clients of mental health and substance abuse services in Birmingham, Graham and colleagues reported that almost one-quarter of participants diagnosed with a mental illness had also been involved in problematic alcohol or drug use within the last year (Graham *et al.*, 2001). Other studies have recorded even larger proportions of their samples with dual diagnosis. In an American study that investigated the prevalence of mental health problems amongst clients attending a substance misuse service, the researchers found that 45 per cent of their sample had mental health problems (Johnson *et al.*, 2002). Moreover, a Canadian study which investigated mental health problems amongst the clients of the Centre for Addiction and Mental Health in Toronto found that 68.6 per cent exhibited '*at least one cluster of psychiatric symptoms*' (Castel *et al.*, 2006:30). Considering drug use separately from alcohol use, a study of mental health patients in an area of South London provided evidence that 15.8 per cent of the study sample had been involved in problematic drug use in the last year (Menezes *et al.*, 1996).

Due to the fact that the term 'dual diagnosis' simply refers to the co-existence of substance misuse and mental health problems, which could include a variety of different disorders and types of substance abuse, the nature of dual diagnosis is similarly complex (Little, 2001). However, one study, mentioned above, has attempted to shed more light on this subject. Castel and colleagues examined clients for '*clusters of psychiatric symptoms*', referring to groupings of two or more mental health disorders. Such clusters included depression consisting of major depression and dysthymia; and anxiety, representing panic disorder, agoraphobia and social phobia (Castel *et al.*, 2006:29). The researchers found that just over a quarter exhibited one cluster of symptoms; 18.9 per cent demonstrated two clusters and 22.3 per cent of participants '*scored positive for three or more clusters*' (Castel *et al.*, 2006:30). Furthermore, the most common clusters of symptoms among the participants were depression, anxiety and conduct disorder.

These findings are similar to Hagedorn and Willenbring's who found that the most common disorders within their study of drug court clients '*were major depressive disorders and post-traumatic stress disorder*' (Hagedorn and Willenbring, 2003:776). Schizophrenia also has strong links to drug and alcohol abuse. In Graham and colleagues' study of mental health and substance abuse service users, those participants considered to have a dual diagnosis (one-quarter) were also 'most likely' to suffer from schizophrenia (Graham *et al.*, 2001:448). Similarly, Littrell and Littrell argue that '*research suggests that nearly half of all patients with schizophrenia*' are also problematic users of drugs and alcohol (Littrell and Littrell, 1999:S17).

Returning to the work of Castel and colleagues, this study also investigated the types of substance abuse most associated with multiple clusters of symptoms. They found that over a third of people who abused alcohol showed no signs of symptom clusters, compared to 26.9 per cent of cocaine/crack users and 27.4 per cent of heroin/opiates users. Furthermore, only 19 per cent of alcohol users had three or more clusters of symptoms, whilst a quarter of heroin/opiate users and 26.5 per cent of cocaine/crack users demonstrated three or more symptom clusters. They also found a positive correlation between the number of substances used by an individual and the number of symptom clusters they demonstrated (Castel *et al.*, 2006). As the number of substances a person used increased, so too did the number of symptom clusters they exhibited.

In terms of demographic characteristics of people with co-occurring mental health and substance abuse problems, there is conflicting evidence regarding whether men or women are more likely to have a dual diagnosis. According to Graham and colleagues in their study of service users in Birmingham, the 24 per cent of participants with co-occurring disorders were likely to be white males in their mid-30s, whilst Menezes and colleagues found within their study of mental health patients that '*young male subjects were at higher risk of having substance abuse problems*' (Graham *et al.*, 2001, Menezes *et al.*, 1996:612). Alternatively, a study led by Webster and colleagues, which looked at the impact of gender on mental health and employment barriers among drug court clients in Kentucky, found that female participants had higher levels of psychiatric disorder (Webster *et al.*, 2007). Furthermore, Castel and colleagues found that, within their sample, women tended to suffer more mental health problems (Castel *et al.*, 2006).

Other studies which have looked at the demographic characteristics relating to this group of people include a study of criminal activity amongst adolescent and young adult males; and a study that investigated factors for identifying dual diagnosis within a treatment service (Wiesner and Kim, 2005; Johnson *et al.*, 2002). In Wiesner and Kim's study of offending, they found that young adult men classified as chronic high-level offenders suffered more from depression and substance abuse than similar young men with less frequent offending (Wiesner and Kim, 2005). In their study of identifying factors for dual diagnosis, Johnson and colleagues discovered that unemployment and poor physical health were important predictors of dual diagnosis (Johnson *et al.*, 2002).

### **2.2.2 Treatment for drug misuse and mental health problems**

Research in the UK and overseas has suggested that individuals with dual diagnosis can benefit from the integration of treatment services for both mental health problems and substance abuse (Haddock *et al.*, 2002; Harris and Edlund, 2005; Manley, 2005). Where they co-occur, mental health and substance abuse problems are not independent of each other and therefore, individuals may benefit from access to treatment that is appropriate to both (Haddock *et al.*, 2002: 265).

Research suggests that there are benefits to supporting individuals with dual diagnosis outside the statutory treatment environment. In an evaluation of a 'dual focus fellowship', similar in style to Alcoholics Anonymous, Magura examined the effectiveness of a self-help programme specifically designed for people with a dual diagnosis (Magura, 2008:1904). Magura found that involvement in the 'Double Trouble in Recovery' programme helped individuals with issues surrounding abstinence, managing medication and standard of living. Another study that showed the importance of external sources of support was a work by Clark, which looked at the impact of family support upon treatment success (Clark, 2001). The study found that family support had a positive impact upon treatment outcomes, with financial support linked to recovery and *'care-giving hours...associated with substance use reduction'* (Clark, 2001:93). However, Clark also found that family support did not necessarily alleviate mental health problems.

Another important issue is access to treatment for dual diagnosis. Some studies have suggested that individuals with a dual diagnosis tend not to undergo treatment (Johnson *et al.*, 2002; Rosen *et al.*, 2004). In fact, according to Hagedorn and Willenbring, who investigated mental health problems amongst drug court attendees, *'half of participants who currently met criteria for a disorder reported that they had never received psychiatric treatment'* (Hagedorn and Willenbring, 2003:776).

### **2.2.3 Mental health problems and employment**

The presence of mental health problems often has serious implications for the employment prospects of affected individuals. One American study followed a sample of welfare recipients over a period of six years and looked at the effect of behavioural health problems, or a range of psychiatric disorders including drug and alcohol abuse, upon participants' ability to find and maintain employment (Zabkiewicz and Schmidt, 2007). Within this study, the researchers found that those participants who suffered from depression were almost 50 per cent less likely to pursue employment than those who did not. The study found that *'hostility, interpersonal sensitivity, psychoticism and heavy drug use'* heavily undermined chances of gaining a job (Zabkiewicz and Schmidt, 2007:178). In particular, participants exhibiting symptoms of psychosis were 70 per cent less likely than those without such symptoms to secure employment. In terms of maintaining employment, the researchers found that participants with behavioural health problems kept their jobs for, on average, only 13 months, compared to others who maintained their jobs for 20 months or more. (Zabkiewicz and Schmidt, 2007). Similarly, a European study that looked at the impact of schizophrenia upon employment, in the UK, France and Germany, found that concurrent drug use increased the likelihood of unemployment (Marwaha *et al.*, 2007).

Another study that looked at the impact of mental health problems upon employment was that carried out by Webster and colleagues amongst clients of a drug court programme in Kentucky. Within this project, the researchers provided evidence that female drug users can experience both greater mental health

problems and greater employment barriers than their male counterparts. Looking more closely at the differences in employment barriers between the sexes, the researchers argued that this is not necessarily due to gender but disparity in mental health (Webster *et al.*, 2007). Focusing upon perception of employment barriers as a barrier to employment in itself, Webster and colleagues reported that within their study *'the more the individual perceived barriers to employment, the more likely he/she was to have mental health problems.'* (Webster *et al.*, 2007:264). The authors argued that the female participants may experience greater employment barriers because they also experienced greater mental health problems than male participants.

## 2.3 Crime

Criminal activity and having a criminal record has a significant impact on the extent to which drug users can gain employment and therefore on their uptake of benefits. For this reason this review considers the literature on the link between problematic drug use and crime and summarises: the prevalence of criminal activity amongst drug users; the relationship between the use of particular kinds of drugs and crime; the contribution of drug treatment to reducing criminal behaviour; and the links between the criminal justice system, drug treatment and employment-related interventions.

### 2.3.1 Crime and drug use

Illicit drug use has been linked to criminal activity in numerous studies in the UK and overseas. The relationship between drug use and crime is commonly regarded as one of cause and effect – that starting to use drugs leads to criminal activity, particularly acquisitive crimes, in order to raise money to fund a drug habit. One recent study, for example, found that 80 per cent of parolees in the UK had a history of substance misuse (Kemp *et al.*, 2004). Yet there is also some evidence that committing crime, and particularly incarceration as a result of committing a crime, can lead to drug use, with some offenders becoming addicted to drugs such as heroin or crack cocaine while in the prison system.

In an early study, Mott examined the criminal histories of non-medical opiate users in the UK (Mott, 1975). The study found that a higher proportion of drug users in the study had criminal histories before they began taking opiates than would be expected from a sample of the general population. During the two-year period following identification of their drug use the number of convictions increased and drug offences made up a significant proportion of convictions. Payne-James and colleagues, in a more recent study, examined the characteristics of drug-using prisoners in police custody in London (Payne-James *et al.*, 2005). Of the 113 drug users in their study who were surveyed while in custody in 2003, 93 per cent used heroin and 87 per cent crack cocaine, with 50 per cent using the two simultaneously. Most (80 per cent) drug users in custody were unemployed and most (82 per cent) had served a previous prison sentence, with 54 per cent

using drugs in prison, and a small group (three per cent) stating that they had first started using drugs in prison. Relatively few drug users in custody (38 per cent) had accessed treatment programmes in the past and only ten per cent were in contact with treatment professionals at the time of the study.

### **2.3.2 Type of drug use and crime**

Other studies have explored the links between crime and problematic drug use, particularly heroin and crack cocaine use. In a study of 51 heroin users in the Netherlands, van der Zanden and colleagues found that 70 per cent of their sample reported criminal activity and 50 per cent reported acquisitive crimes prior to starting a methadone maintenance treatment programme (van der Zanden *et al.*, 2007). Offending took place on most days (20.5) of the month with an average of 3.1 offences per day. Acquisitive crime involved primarily shoplifting and theft of bicycles, while theft from vehicles and burglaries were also committed, but less frequently. Most drug users in the study (63 per cent) reported that they had started offending in order to acquire drugs or alcohol.

Cross and colleagues compared the income generation (including income from crime) activities of crack cocaine users with frequent users of other hard drugs in Harlem, New York in 1998 and 1999 (Cross *et al.*, 2001). They examined the sources of income of frequent (used in at least 15 of the past 30 days) crack users with subgroups of less frequent hard users. Compared with not frequent (less than 15 days) hard drug users, frequent crack users were more likely to have committed theft and to have engaged in sex work than other drug users in the study. They were equally likely to be involved in drug dealing or drug distribution activities but were less likely than other drug users to be in employment (full- or part-time) or to be receiving benefits. The authors concluded that crack users were a particularly marginalised subgroup of drug users who were more likely to be engaged in crime to fund their drug use.

Bennett and Holloway examined the association between multiple drug use and crime by analysing data from the English and Welsh arrestee drug abuse monitoring programme (Bennet and Holloway, 2005). They found that both the number of drug types consumed and particular drug type combinations explained offending rates. This study built on their previous work that showed that arrestees who had used heroin, powder cocaine and crack in the three days prior to interview had higher illegal incomes than those who either used heroin without powder cocaine and crack, or indeed powder cocaine and crack without heroin (Bennett, 2000). The 2005 study found that in a sample of 3,135 arrestees in England and Wales, around one-third of single drug users compared with two-thirds of multiple drug users reported that they had committed one or more acquisitive crimes in the past year. They also found that the mean rate of offending was twice as high in the case of multiple drug users as single drug users in the past year. The highest offending rates were found amongst users of heroin and crack who also used heroin substitutes, recreational drugs and/or tranquillisers.

### 2.3.3 Drug treatment and crime

Drug treatment programmes exist primarily to support people to reduce their drug use or achieve abstinence. However, they also have secondary aims and one of these can be to try and reduce criminal behaviour in users who have committed crimes in the past. Holloway and colleagues conducted a systematic review and meta-analysis of the effectiveness of drug treatment programmes in achieving this aim (Holloway *et al.*, 2006). They identified 28 evaluations of treatment programmes (from a range of countries) that they included in their review. Overall, they found that the mean odds of offending following treatment were significantly lower among users who had received treatment than among the comparison groups in the studies. Unsurprisingly, however, the size of effect did vary depending on client characteristics and by the type of programme, as well as the research methods employed by the studies included in the review.

It is also worth highlighting the findings of a slightly more recent study not included in the Holloway review. This was Luchansky and colleagues' analysis of outcomes from treatment for alcohol and drug users receiving the Supplemental Security Income (SSI) benefit in Washington state, USA (Luchansky *et al.*, 2006). They tracked a large sample ( $n=8,343$ ) of benefit recipients and examined to what extent those who received treatment committed crimes in the one-year period following the end of their treatment episode. Having completed the full treatment programme or having an episode of treatment that lasted at least 90 days was associated with reduced rates of criminal activity amongst the sample.

### 2.3.4 Drug treatment, crime and employment

A much smaller body of literature has examined outcomes from integrated services that aim to improve outcomes for PDUs who commit crimes, in particular, services that combine rehabilitation and/or drug treatment with support to move towards employment. Various studies have looked at the effect of treatment on crime rates amongst ex-offenders: for example, some studies have explored outcomes from drug treatment delivered as part of a probation order in the UK and suggest that large reductions in drug use and crime can be achieved (see, for example, Hearnden, 2000; Dorn and Seddon, 1996). However, we could find only one UK evaluation of an intervention that aimed to combine drug treatment for offenders with support to obtain employment.

Kemp and colleagues explored a number of strategies and interventions developed in the UK from 1999 to 2001 to help parolees who were receiving drug or alcohol treatment to find employment (Kemp *et al.*, 2004). They point out that as approximately 80 per cent of parolees have a history of substance misuse and almost all are unemployed when leaving prison, treatment should be offered at the same time as support to move towards employment. However, the extent to which parolees receive effective support with both varies significantly. In their study, 245 parolees who were taking part in an outpatient treatment programme were allocated voluntarily allocated (not randomised) to one of four different

vocational programmes. They found that most (78 per cent) parolees completed the vocational programme and just over half (55 per cent) were able to find a job. Completing the vocational programme was strongly associated with finding a job at one year follow-up. The article also highlights some of the challenges as well as useful lessons for the delivery of integrated drug treatment and employment services.

## 2.4 Treatment of drug misuse

Our search strategy identified a number of studies relating to drug treatment. However, because of the extensive literature on this topic, we screened only for studies on this topic that reported recent UK evidence, and in particular studies that considered the effects of treatment on substance misuse as well as other outcomes (such as employment or reduced offending) relevant to our research.

### 2.4.1 Treatment outcomes

Evidence from UK studies suggests that drug treatment works. Good quality treatment programmes can produce positive results, with studies noting important long-term outcomes in relation to reduced drug misuse and offending, as well as improvements in mental and physical health. However, other studies, which have focused more on short-term outcomes, have highlighted some of the challenges inherent in the treatment and recovery process.

One example of this was a study led by Keen and colleagues who investigated a residential treatment programme in Sheffield. The researchers looked at the extent to which patients admitted to the programme stayed in treatment and the nature of their departure and concluded that the treatment programme suffered from high levels of patient drop-out. Only 13 per cent of patients left after successful completion of treatment compared to 68 per cent who left due to '*unplanned departure or eviction*' (Keen *et al.*, 2001:545). Another more recent study which highlighted the issue of patient retention was one that investigated a treatment programme designed to help offenders addicted to opiates (Keene *et al.*, 2007). As in the previous study, the extent to which participants dropped out of this treatment programme was substantial, with only 59 of the 103 people that initially agreed to take part remaining in treatment for at least six weeks. The researchers also found that certain individuals were more likely to commit to treatment than others. Being female, older, using intravenously and using multiple drugs increased a person's chances of dropping out of a treatment programme. Whereas men, people from an ethnic minority background and individuals who did not inject drugs were more likely to complete. The treatment response of individuals with particular characteristics was also an important issue within a study of various therapies based in a treatment agency in London. The investigation, led by Yandoli and colleagues, found that unemployment and, similar to the previous study, intravenous drug use, tended to undermine treatment success (Yandoli *et al.*, 2002).

Despite the difficulties of tackling drug misuse in the short-term, longer-term outcomes for those who complete a programme can be more positive. One of the main studies to examine long-term treatment outcomes in the UK was the National Treatment Outcome Research Study led by Gossop and colleagues (Gossop *et al.*, 2002). Focusing on 54 drug treatment agencies in England, involving both residential and community programmes, the researchers interviewed new entrants to the programmes and subsequently followed them up with further interviews at one- and two-year intervals. The researchers found that after two years, most participants had maintained or improved upon the successful outcomes they had exhibited a year after entering treatment. They found that in the two years following treatment, participants had increased rates of abstinence and had reduced their abuse of heroin, non-prescribed methadone, benzodiazepines and crack cocaine. The researchers also found that intravenous drug use had fallen, with 37 per cent of residential participants and 42 per cent of community participants injecting at year two, compared to 63 per cent and 61 per cent at treatment entrance, respectively. Moreover, the study found that in the two-year period following treatment, the physical and mental health of participants improved. In particular, they highlighted that the percentage of people who underwent residential treatment with suicidal thoughts halved in two years.

In Scotland, a similar study of treatment outcomes also had positive findings. Beginning with interviews of a sample of new entrants to treatment programmes across Scotland, the researchers re-interviewed participants eight months later and found improvements in participants' physical health, mental health and levels of abstinence from drug-taking (Morris and Gannon, 2008)

As mentioned earlier, treatment has also been found to have a positive effect upon drug users' involvement in crime. Crossen-White and Galvin examined an Arrest Referral Scheme, where drug-using offenders were offered access to treatment after police arrest (Crossen-White and Galvin, 2002). The researchers re-interviewed participants to the scheme after 18 months, and found that the majority of people that had participated in treatment had become drug-free in the intervening period. Furthermore, 88 per cent of the group that were drug-free at 18 months had also given up offending. Further evidence of the potential effects of treatment on offending is provided by Holloway and colleagues who reviewed evaluations of 28 drug treatment programmes, with the objective of assessing the impact of drug treatment on offending behaviour (Holloway *et al.*, 2006). Although the authors of the study cautioned that their results differed according to what type of treatment programme they were considering, overall they were able to conclude that treatment reduced the likelihood of further offending.

## 2.5 Drug use, employment and unemployment

In recent years, research has increasingly examined the relationship between problem drug use and unemployment. Using data from the British Crime Survey (BCS) (a household victimisation survey that is representative of the adult population



of England and Wales), MacDonald and Pudney investigated the effect of drug use upon employment outcomes, with specific focus upon actual participation in employment, and wages (MacDonald and Pudney, 2000, 2001).

In the first of two MacDonald and Pudney papers reviewed here, the researchers present findings from their analysis of data extracted from the 1994 and 1996 data-sets of the BCS (MacDonald and Pudney, 2000). Combining the two datasets, the authors analysed responses from all participants aged 16 to 50 who provided complete responses in relation to drug misuse. Participants aged 50 plus were excluded based on the authors' belief that drug misuse beyond this age is very limited.

The authors then conducted a multiple regression analysis to produce estimates for two models of the probability of current unemployment, examining various factors, including past drug use. The two models of current unemployment took into account two different approaches to classifying drug use. Where the first model employed a classification, devised by the authors, that distinguished between recreational drugs such as LSD, amphetamines and cannabis; and dependency drugs such as opiates, crack cocaine and powder cocaine, the second model followed the classification associated with the Misuse of Drugs Act of 1971 (MDA), which groups together opiates and LSD as class A drugs. In each model the researchers produced estimates for each gender based on two age groups: 16 to 25 and 26 to 50.

The study had two main findings: First, it found there was no relationship between the past use of 'soft' drugs, such as cannabis or amphetamines, and current unemployment, except in the case of young women (for both models). Secondly, they found that for most groups there was a positive relationship between past use of 'hard' drugs, such as opiates or crack cocaine, and current unemployment. The only exception to this being, older women; and young men in the authors' first model.

In the second of the two MacDonald and Pudney papers reviewed here, the researchers describe further efforts to examine the impact of drug use upon employment outcomes (MacDonald and Pudney, 2001). The second study focused more on the impact of drug use on 'occupational attainment' or wages, but also involved a re-examination of the impact of drug use upon unemployment. Within this investigation, the authors used BCS data from the 1994 survey; increased the upper limits of both age cohorts, and included survey participants up to the age of 59. Moreover, they adopted a drug-use classification of 'hard' and 'soft' drugs which followed that set out in the MDA.

The results of this analysis, compared to MacDonald and Pudney's earlier study, exhibited both similarities and differences. Within the second study, similar to the first, past hard drug use within the older cohort increased the probability of current unemployment, and past soft drug use was found to have no significant association with unemployment. In contrast to the earlier study, however, results

from the second analysis showed that within the 16-29 age group past soft drug use was associated with current unemployment, whilst there was no significant relationship between hard drug use and unemployment. Thus, considering both papers, it appears that some of the authors' results are contradictory, but this may be due to the different approaches to analysis adopted in the two papers. Nevertheless, both papers concluded that past hard drug use, such as heroin and crack cocaine use is related to unemployment in later life.

An earlier study examining the relationship between drug use and unemployment was conducted by Peck and Plant in the UK in the early 1980s (Peck and Plant, 1986). The authors carried out an analysis of a longitudinal study of young adults in the Lothian region of Scotland and also UK national data relating to unemployment, drug misuse offences and treatment in the period 1970-84. The study in Lothian involved initial interviews with over a thousand 15/16 year olds in 1979/80. The majority of participants (811) were re-interviewed in 1983. The authors concluded from their analysis that unemployed male participants in 1983 were more likely to be involved in drug use than those who were not unemployed; and that the duration of unemployment was '*weakly but positively associated*' with the number of drugs an individual had used (Peck and Plant, 1986: 930). In contrast, the authors found no significant association between unemployment and drug use amongst female participants.

Within their analysis of UK national data, Peck and Plant calculated separate correlation co-efficients for the relationship between average annual unemployment rates and drug-related offences, and unemployment rates and numbers of people in treatment. From this analysis the authors concluded that drug use and unemployment were indeed related.

As highlighted by Peck and Plant themselves, there are limitations within both elements of this study. The longitudinal survey of adolescents and young people in the Lothian region was restricted by a focus on one area and a particular age group. Furthermore, reliance on the use of correlation co-efficients which examine the relationship between two variables excludes consideration of other important and perhaps intervening factors.

Both studies discussed above examined the issue of whether drug use and unemployment are related but neither fully investigated the characteristics that may increase the likelihood of a drug-using individual being unemployed. In an American study of 380 heroin users receiving a methadone substitute from five inner-city treatment agencies, researchers identified a number of factors that were significantly related to unemployment risk (Hermalin *et al.*, 1990). Two important predictors were race and having a high school diploma. Black people were 2.5 times less likely to be employed in the last three years than white people and those with a high school diploma were almost twice as likely to be employed as those without. Factors which were found to increase the likelihood of employment in the last three years included ever having received job training, ever having been fired from a job and ever having received unemployment benefit. Interestingly, contrary

to findings from other studies, current heroin use also increased the likelihood of employment in the last three years. Other than race, factors that undermined the probability of employment in the last three years included welfare benefits being a primary source of income, having a lack of desire to work and not knowing how to look for work (Hermalin *et al.*, 1990).

## 2.6 Employability

In addition to examining whether drug users are more or less likely to be employed, some studies have explored the wider factors that facilitate or prevent employment amongst this group. Other research has described how drug treatment can affect employment and other interventions that can support drug users in finding jobs. Each of these themes relates to the concept of 'employability' and we explore each one in turn.

### 2.6.1 Barriers to employment

PDUs can face significant problems in finding and maintaining employment. A study of 30 current and recovering drug and alcohol users in the English Midlands recently described the type of employment that individuals had held, and found two main types. The first category related to occasional employment, which altogether amounted to a few years over a period of decades; and the second category to more or less continuous employment but in short-term temporary work which '*entailed low paid, unskilled labouring, often on a day to day basis, typically based in warehouses and factories*' (Cebulla, 2004:1049).

Sutton and colleagues conducted a literature review for the DWP, published in 2004, that examined in some detail the barriers that can prevent drug and alcohol users from gaining employment at all, or being limited to occasional or poorly paid employment of the kind described by Cebulla above (Sutton *et al.*, 2004). Sutton and colleagues identified six major areas of disadvantage including education/skills; health; social disadvantage, provision of support services, engaging with employers and support professionals and dealing with stigma. In terms of education, the authors suggest that many drug users have poor educational attainment. In particular, their review highlighted a study which compared substance abusing women receiving welfare benefits with a comparable group of women who did not use drugs (Atkinson *et al.*, 2001 cited in Sutton *et al.*, 2004). The American researchers found that the women on welfare who did not use drugs tended to have '*significantly higher basic skills (reading, writing, arithmetic) and office skills (operating telephone system, typing)*' than those who did use drugs (Sutton *et al.*, 2004:6).

Health issues can also be a barrier to employment for drug users. As highlighted in earlier parts of this review, prolonged drug use can cause individuals to suffer substantial physical and mental health problems that can have serious implications for employability. Neale and Kemp, in a study of drug outcomes in Scotland, found that many participants struggled to carry out simple physical tasks, including, for

example, walking even short distances (Neale and Kemp, 2005). Furthermore, Sutton and colleagues' review highlighted the extent of mental health problems amongst drug users with reference to Klee and colleagues' study which found that over a quarter of drug-using participants were taking anti-depressants (Klee *et al.*, 2002 cited in Sutton *et al.*, 2004). Moreover, Sutton and colleagues draw attention to the use of substitute medication. According to the review authors, Neale suggests that substitute drugs such as methadone, which are used to treat drug addiction, can bring about debilitating side effects that interfere with everyday tasks (Neale in Sutton *et al.*, 2004). Furthermore, Sutton and colleagues also discuss the issue of drug users' participation in treatment. The authors refer to a review of barriers to employment in Scotland which found that the most frequent obstacle faced by drug users involved gaining permission to take time off work or college courses in order to attend treatment services or pick up substitute prescriptions (Sutton *et al.*, 2004).

Drug users can also be hampered in their search for employment due to what Sutton and colleagues describe as social disadvantage in the form of crime and financial problems (Sutton *et al.*, 2004). Crime can be a barrier to employment due to the fact that many drug users engage in illegal activity, often to finance their drug use. The result is that drug users tend to have previous convictions which can be very discouraging for employers. Sutton and colleagues refer to evidence of such attitudes in a survey carried out by the National Association for the Care and Resettlement of Offenders (NACRO) in London in 1999 (NACRO, 2000 cited in Sutton *et al.*, 2004). Though the review authors note the limitation of the survey in terms of response rate (11 per cent), they assert that the findings demonstrate the hesitation of employers in considering ex-offenders. Financial problems can also act as a barrier to gaining employment due to PDUs' typical sources of income (Effective Interventions Unit, 2001 cited in Sutton *et al.*, 2004). The pressure of debts can lead drug users to prioritise achieving financial relief in the form of immediate, informal employment over the wider benefits of long-term, legal employment; whilst drug users on incapacity benefits face the prospect of temporary financial insecurity if they give up their benefits and go into employment.

Other important barriers to employment described in the same review centre on the provision of support services and the ability of drug-using individuals to engage with such services and employment. Although the review authors acknowledge that the provision of specialist employment services has grown, they draw attention to the location of such services. Due to the fact that services are generally situated in larger urban areas, rural drug users can find it hard to make use of available support. Even when drug users have access to services, however, they may find it difficult to engage with the services provided because of poor confidence and interpersonal skills. Sutton and colleagues describe how lack of confidence, which in some cases can be manifested in anger, can make it difficult for drug users to build a rapport with employment support professionals. Furthermore, within actual employment, poor interpersonal skills and the tendency to engage in behaviours that would be commonly unacceptable in the workplace

can be highly detrimental to their employability. This was demonstrated in an American study that examined the behaviour of 53 PDUs within a therapeutic workplace (Carpenedo *et al.*, 2007). A therapeutic workplace is an employment support approach, which according to Carpenedo has three main objectives including: maintaining drug abstinence, improving job-skills and providing supported employment. With participants involved in the task of learning a variety of keyboard skills, the researchers observed a wide variety of behaviours. Most common behaviour 'violations' included participants falling asleep during work and talking loudly, which was against the rules of the workplace. Other more severe behaviours, though rare, related to four participants who were involved in arguments, shouting, swearing and use of threatening language. Further analysis showed that with regard to productivity, the number of times participants fell asleep was positively associated with the number of incorrect keystrokes used in two of the keyboard training programmes.

A final barrier highlighted by Sutton and colleagues' review related to drug users' ability to deal with the stigma (both perceived and actual) that they face. The review authors describe how drug users can struggle to establish beneficial relationships with support professionals due to a fear about how they are perceived. For example, a survey of 115 drug users conducted by the Glasgow Street Intervention Group revealed that *'75 per cent of participants perceived benefit agency and employment services staff to show a negative attitude or rejection towards them.'* (Sutton *et al.*, 2004:11)<sup>2</sup>. Another dimension to the issue of stigma is the fear felt by drug-using mothers regarding the loss of their children. Sutton and colleagues highlight Scottish research which showed that drug users who are mothers are often more reluctant to attend drug treatment services for fear of having children removed from their care (New Futures Fund Initiative (NFFI), 2000 and Effective Intervention Unit (EIU), 2001 cited in Sutton *et al.*, 2004). Other research suggests that these fears are legitimate: research carried out by Morgenstern and colleagues, regarding the employability of female drug users receiving welfare benefits (Morgenstern *et al.*, 2003) found that compared to other female welfare recipients who did not use drugs, drug-using participants experienced a higher incidence of child welfare investigations, in addition to domestic violence, mental illness, legal problems and fewer job skills.

Finally, a major obstacle to achieving and maintaining employment is the issue of continuing drug use. In a study carried out by Cebulla, Smith and Sutton in the English Midlands which involved examination of the employment aspirations of 30 current and recovering drug and alcohol users, the authors concluded that perceptions of readiness for work reflected perceptions of drug or alcohol problems (Cebulla *et al.*, 2004). Drug-using participants felt that their addiction was a medical condition and future employment was dependent on whether

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<sup>2</sup> Sutton *et al.*, 2004 refers to the website address <http://www.gsig.org.uk/surveys/bte.html> as the source of the Glasgow Street Intervention Group report. This website is no longer available.

or not this condition could be 'cured'. Those that thought their condition was 'insurmountable' could not foresee a return to work whilst those that thought recovery possible, also felt '*it promised an almost instant ability to return to regular employment*' (Cebulla *et al.*, 2004:1051). Moreover, Kemp and Neale argue that the chaotic nature of most drug users' lives makes it very difficult for them to maintain employment. From their analysis of the Drug Outcomes Research in Scotland (DORIS) study, they reported that six out of ten respondents '*admitted that their drug use was always or nearly always out of control*' (Kemp and Neale, 2005:39).

### **2.6.2 The impact of drug misuse treatment on employment**

The primary aim of drug misuse treatment is obviously the reduction or cessation of drug misuse amongst affected individuals, but often other desirable outcomes of treatment relate to employment. From the literature reviewed in this project it seems that the relationship between treatment and employment is not entirely straightforward. Three studies discussed in this section argue that treatment can have a positive impact upon employment outcomes, however, a further two articles suggest that the effect of treatment is more limited. A sixth article discussed below, which perhaps bridges the gap between these two view-points, highlights the importance of providing employment support as part of treatment programmes.

In an American study carried out by Zarkin and colleagues, researchers sought to investigate the effect of treatment completion and length of stay in treatment on employment outcomes (Zarkin *et al.*, 2002). Using data from the National Treatment Improvement Evaluation study, the authors extracted the records of 986 individuals who were enrolled in out-patient drug treatment programmes across the US and had been successfully interviewed three times: at treatment intake, at discharge and at one year following treatment. The researchers found that the length of stay in treatment and treatment completion were significantly associated with employment. Furthermore, they found that if length of time in treatment was kept constant, patients who completed treatment were almost twice as likely to achieve employment, as those who did not. Similar results were also found in another American study that examined the impact of treatment upon employment outcomes in the case of 100 substance-abusing women receiving welfare benefits (Metsch *et al.*, 1999). As with the previous study, the researchers found that length of time in treatment, particularly a period of one year, and treatment completion increased the likelihood of employment. A further American study which demonstrated the relationship between treatment and employment was that carried out by Ginexi, Foss and Scott amongst a large sample of drug users registered with treatment services in Chicago (Ginexi *et al.*, 2003). Interviewing over 1,000 eligible participants at treatment intake, the researchers carried out further interviews at intervals of six, 24 and 36 months. Ginexi and colleagues found that at every follow-up point after intake the number of people looking for work and in employment increased. However, men were more likely than women to be looking for work at six and 24 months after treatment, as were those who did not live with family or friends. The researchers also found that ongoing drug use, participation in treatment and mental health problems increased the likelihood of leaving the labour force.

In contrast to the above studies, our search strategy also identified two articles that suggested a more complicated relationship between treatment and employment. In a study conducted by DeAngelis and colleagues in Los Angeles in the late 70s, the researchers found that employment status remained largely stable over a period of a year following treatment. Following an overall total of 186 drug users that entered treatment within a one-year period, the authors interviewed participants at intake and every three months following that, up to a year after intake. They found that although rates of employment increased following treatment, it appeared that a core group of people experienced no change in their work status. As outlined by the researchers *'those who are employed remain employed and those who are unemployed remain unemployed'* (DeAngelis, 1978:1199). A further study which suggests that there is more to the relationship between treatment and unemployment was one conducted in Denmark in the late 1970s and early 1980s. The researchers, Segest, Mygind and Bay investigated a group of 169 opiate users who had been prescribed methadone from a GP based in Copenhagen, following them over a period of eight years. In Denmark, at this time, the prescription of methadone was only deemed appropriate for 'severely affected drug addicts', thus the participants in this study all had many years' experience of daily intravenous drug use (Segest, *et al.*, 1990:54). Concluding their investigation, Segest and colleagues found that there was no clear relationship between the use of methadone and employment. It is important to point out, however, that only 11 per cent of the sample had received methadone on a sustained basis in this study.

A more recent and relevant study exploring this issue was that conducted by McIntosh and colleagues in Scotland. Analysing data from the DORIS study, the authors sought to discover what elements of drug misuse treatment had greatest impact on subsequent employment. The DORIS study was a longitudinal study which recruited a cohort of participants entering treatment in agencies based across Scotland in 2001. After first interviewing at treatment intake, participants were then re-interviewed a further three times, after eight, 16 and 33 months. The authors discovered from their analysis that although abstinence from drug use was closely associated with employment, other factors also had to be taken into account. The study found that the most powerful predictor of employment was participants receiving direct assistance from their treatment agency to obtain a job, employment-related skills, or education. (McIntosh *et al.*, 2008).

### **2.6.3 Facilitating the employment of drug users**

The literature relating to the ways in which current or former drug users can be supported to gain employment is fairly extensive. A review of literature in this area was conducted by Platt in the early 1990s and we include the main findings from this here, supplemented by more recent research (Platt, 1995). Platt provided an overview of a variety of different programmes aimed at supporting drug users to gain the skills and confidence to find and maintain employment (Platt, 1995).

According to this review, types of employment intervention that had '*met with varying success*' included programmes that involved supported work; job-seeking and placement; and personal competency and skill-building (Platt, 1990:423).

Three relatively recent journal articles identified by our search strategy outline three very different programmes of support. In the first of these articles, Kidorf and colleagues describe an employment intervention for opiate users in the USA called Motivated Stepped Care incorporating different levels of counselling support and behavioural reinforcement (Kidorf *et al.*, 2004). This intervention involves three steps, where advancement to higher steps of care is dependent on continuing drug abstinence and attendance at counselling sessions, or failure to find employment. Non-compliance with steps 1 and 2 result in advancement to the next stage, with step 3, the final step, involving the most intensive requirements. At step 3, participants were required to attend nine hours of individual and group counselling sessions every week for four weeks whilst also remaining drug-free. Those failing to meet the requirements of this phase were prescribed a 30-day methadone reduction as part of a process of discharge. According to the authors, out of the 228 individuals considered to be capable of achieving employment that took part in the intervention, 93 per cent entered employment or training. Eighty-nine per cent of those were in full- or part-time jobs, three per cent participated in voluntary work and one per cent had enrolled in educational courses.

A further employment intervention developed by researchers in the US was a programme that focused upon achieving, sustaining and advancing employment amongst a large cohort of drug court clients in Kentucky (Leukefield *et al.*, 2007). Outcomes from the intervention were examined in a randomised controlled trial that split a sample of 500 drug users into an intervention group, and a control group who received no support. Leukefield and colleagues examined the impact of intervention sessions that involved job readiness assessments, life skills development and identifying possible employers. Following up study participants after 12 months, the researchers found a significant association between degree of intervention and employment in the last year. Participants who attended a large number of intervention sessions tended to report more full-time employment (83 per cent), compared to those who attended few sessions (54 per cent).

The third relevant study related to an employment support intervention called Customised Employment Supports (CES), designed for individuals with a substitute prescription for methadone. At two methadone treatment agencies in New York, the researchers trialled their '*innovative vocational rehabilitation model*' amongst 168 clients, by providing counselling that sought to confront a variety of barriers to employment. As well as addressing issues such as a lack of appropriate job skills or employment experience this intervention model also attempted to overcome such issues as poor confidence and '*fear of leaving an unstructured lifestyle for the demands of competitive employment*' (Magura *et al.*, 2007:815). Results of the evaluation, however, showed that the CES model had limited impact upon employment outcomes compared to the standard counselling received by the



study's control group. It was found that those who received the CES intervention were more likely to achieve employment in terms of a mixture of formal and informal jobs, as well as informal work only, compared to those receiving traditional support. However, clients receiving the CES intervention did not experience any advantage over the control group with regard to formal employment and earnings.

In their review of the literature regarding barriers to employment for drug and alcohol users, Sutton and colleagues also reviewed the effectiveness of a number of employment support programmes (Sutton *et al.*, 2004). Three of the programmes evaluated were British and were based in Coventry and Warwickshire, Guildford and Glasgow. As part of the project based in Coventry and Warwickshire, two employment placement workers were situated in community drug teams in two areas and helped recovering drug users to improve their job-hunting skills, including interview technique and filling in application forms. In Guildford, 16 participants attended a 12-week course at the University of Surrey, aimed at supporting participants to achieve employment and sustain abstinence. The Kickstart project in Glasgow, operating in collaboration with local agencies and employers, sought to improve the employment prospects of recovering drug users through motivational advice, training in basic skills and promoting work readiness.

In evaluating the effectiveness of the employment support programmes they reviewed, Sutton and colleagues identified several factors they felt had contributed to the success of certain projects. These included strong inter-agency working, allowing for understanding of respective challenges and the development of trust; good links with local employers; and ongoing support for drug users, especially with regard to relapse and the ability to refer to other support services (Sutton *et al.*, 2004).

## 2.7 Interaction with the benefits system

Our earlier work for the DWP, summarised in the introduction to this report, aimed to estimate the number of PDUs accessing benefits in England (Hay and Bauld, 2008). In our review of the literature for the current study, we searched for other related studies but were unable to find any other UK evidence of the same type. However, there is a limited international literature that provides some evidence of the links between drug use and welfare receipt, primarily in the USA. We summarise this literature here and also describe findings from studies that have explored the reasons why drug users access and remain on benefits.

### 2.7.1 The extent to which drug users access benefits

In the USA, the extent of welfare receipt amongst drug users has been reported by a number of studies, particularly in the 1990s. However, the way these studies define drug use and whether they separate illegal drugs from other forms of substance misuse varies widely. For example, Henderson and colleagues provide recent estimates of the percentage of welfare recipients with drug and alcohol problems, stating that the proportion ranges between nine and 20 per cent

(Henderson, 2006). Specific examples of estimates include the 1998 National Household Survey of Drug Abuse in the USA which found that 20 per cent of recipients of one of the main federal benefits (Temporary Assistance for Needy Families (TANF)) reported illicit drug use at some point in the past year (Pollack 2002) and that households where residents were in receipt of welfare were 50 per cent more likely to be involved in drug use than households with no welfare recipients (Delva *et al.*, 2000). Another survey found that 12.5 per cent of 18-24 year old female benefit recipients were regular users of drugs, excluding alcohol (Woolis, 1998).

Despite some evidence regarding the extent of drug use amongst welfare recipients in the US, other American research suggests that few affected individuals disclose their drug use to the relevant authorities. In a study carried out by Morgenstern and colleagues in New Jersey, researchers found that only one to four per cent of welfare clients were referred for substance abuse treatment by their welfare agency (Morgenstern *et al.*, 2001 cited in Henderson *et al.*, 2006).

The extent of misidentification of drug use amongst welfare recipients has had further implications in the context of welfare reform, which took place in the US in the mid-1990s. Reform of the US welfare system instituted a new approach which emphasised welfare recipients leaving welfare and moving into employment. Thus, following reform, welfare agency staff were required to assess the employability of welfare recipients, including the identification of any substance abuse problems. If welfare recipients were identified as substance abusers they would then be required to participate in treatment in order to continue receiving welfare support. Recognising the disparity between estimates and actual referrals, Henderson and colleagues studied the issues surrounding the identification of substance using individuals by welfare agency workers in one county of California, over a period of two and a half years. The authors found that front-line workers face numerous barriers in identifying drug users among welfare recipients. Firstly, they discovered institutional barriers, relating to the absence of basic identification tools and inappropriate training. Welfare agency workers in this part of California had no access to a standardised screening instrument which could have assisted them in interviews with welfare recipients and flagging potential substance abuse problems. Instead, workers had to rely on the self-disclosure of clients, in addition to looking for signs of drug use, as informed by professional training. However, agency workers pointed to flaws in this training, suggesting that it provided only generic information, and some commenting that certain '*identifiers are too broad or vague to be useful*' (Henderson *et al.*, 2006:225). Further barriers to identifying drug misuse were discovered in terms of a change in work conditions, the delicate nature of worker-client relationships and professional outlook. In terms of work conditions, the authors point to a large expansion in the workload of agency officials due to welfare reform. Prior to changes in the welfare system, the authors argue that many welfare officials were simply tasked with the job of assessing the eligibility of clients for financial support. After welfare reform, however, the responsibilities of welfare agency workers were expanded to include assessment

of recipient employability, involving consideration of a variety of issues. Thus, according to Henderson and colleagues, workers were expected to *'provide more intensive, personalised attention to clients'* which in practice entails more time (Henderson *et al.*, 2006:226) Thus, the researchers argue that time pressures could force welfare officials to only concentrate on certain issues presented by clients and sideline other important issues such as substance misuse.

Another barrier to identifying substance abuse amongst welfare clients was found in the nature of the worker-client relationship. Welfare officials expressed how they found it difficult to broach the subject of substance misuse with clients, for fear of undermining their relationship and any beneficial outcomes. Workers wanted to build a rapport with clients where they would feel sufficient trust to freely discuss more sensitive issues. Thus, it seemed that workers chose not to confront clients about potential substance abuse, laying the basis for a stronger relationship. In the words of one employment specialist: *'I guess I could probably say to them, 'Do you have a drug problem?' but I feel like that's going to stop the whole communication. I'm trying to build a relationship where they're comfortable'* (Henderson *et al.*, 2006:228).

A final barrier to identifying substance misuse amongst welfare clients discovered by Henderson and colleagues related to welfare officials simply not registering the substance abuse problems presented by welfare clients because such issues fell outside their frame of reference. The researchers describe how workers may have missed certain issues presented by clients because they may not have seen them as relevant to their job, especially in the early days of welfare reform, when workers may have felt they lacked the knowledge needed to accurately carry out identification. This was articulated by one worker who said *'It takes a long time to make such a huge conversion, not only just in paper trails and all those kind of things, but then in the mental, what's going on within the brains of workers.'* (Henderson *et al.*, 2006:230).

### **2.7.2 The relationship between drug use and welfare dependency**

Other research from the US has examined the views of drug users while on benefits and routes in and out of the benefit system. Luck and colleagues conducted in depth interviews with 61 'active' female drug users who were not in treatment but were accessing benefits in Atlanta, USA (Luck *et al.*, 2004). The researchers explored the women's views regarding their experiences with welfare, drug use patterns while on welfare and additional sources of income while on benefits. Most women viewed social welfare positively, in particular receipt of housing-related benefits and income for food. However, they reported being stigmatised by welfare employees and case workers and reported that once drug use had been disclosed or discovered, they were likely to be treated more negatively. Most women in the study (70 per cent) reported additional income, primarily from illegal sources such as prostitution, drug dealing or drug-related activities. However, the authors found that the main difference between women who had

no income other than welfare and those who did was that the latter were more heavily involved in using drugs, particularly crack cocaine. Overall, the authors found that the relationship between drug use and welfare receipt was dependent on a number of factors. Important factors found to be driving welfare dependency were lack of education/skills, poor employment opportunities and problems with child-care. Importantly, the women interviewed did not feel there was any direct link between their drug use and welfare receipt, but rather that their welfare dependency was driven by other factors in their lives (Luck *et al.*, 2004).

Schmidt and colleagues conducted a cohort study that followed up welfare recipients with substance misuse (drug and alcohol) problems and compared them with welfare recipients without these problems (Schmidt *et al.*, 2002). Baseline data was collected from 606 welfare recipients in Northern California in 1989 and 411 of these (69 per cent) were successfully followed up six years later, in 1995. These individuals were receiving either of the two main cash aid benefits available in California at the time (Aid to Families with Dependent Children (AFDC), and General Assistance (GA). The study compared routes in and out of the benefit system between the 22 per cent of the sample who met the criteria for substance dependence at baseline interview with those who did not. The researchers found that individuals with substance misuse problems experienced more periods on welfare during this six-year period than other interviewees. More than half (55 per cent) of the substance-dependent benefit recipients experienced two or more periods on welfare, with one-third experiencing three or more. In contrast, 40 per cent of those without substance misuse problems experienced two or more periods on welfare and 14 per cent experienced three or more spells (Schmidt *et al.*, 2002).

The study also examined the reasons why people moved off benefits. Individuals with substance misuse problems were less likely than others to cite employment as the main reason for moving off benefits and more likely to cite administrative or family reasons. Administrative reasons included losing eligibility due to going to prison (individuals with substance abuse problems were three times more likely than others to cite this as a reason), failing to comply with training or employment requirements, and failing to complete necessary paperwork or attend appointments. Individuals with substance misuse problems were also more likely than others to cite family reasons such as residential moves or changes in the number of children living with them as the reason why they were no longer in receipt of a particular benefit such as AFDC. The authors point out that they did conduct additional analyses disaggregating cases of alcohol and drug dependence, although these are not reported in any detail in the paper. They found similar relationships, but stronger effects for drug dependence (Schmidt *et al.*, 2002).

## 2.8 Welfare reform

A limited body of literature has explored the extent to which welfare reform, of the kind currently underway in the UK, has affected benefit uptake by drug users or other relevant outcomes for this group such as higher levels of engagement with treatment while on benefits. Some countries have implemented reforms which are related to the changes now underway in the UK<sup>3</sup>, in particular reforms that have introduced the principle of conditionality – that benefit receipt from drug users is conditional upon engagement of some kind. Countries such as South Africa, the USA and parts of Australia and Canada have introduced such reforms (MacDonald *et al.*, 2001; de Miranda, 1989).

However, very little research has been conducted to evaluate the impact of such changes except in the USA. There is a body of American literature outlining the effects of major reform of the welfare system which took place in the mid-1990s. A number of studies have examined how these reforms affected people with substance misuse including PDUs.

In the USA, the federal government introduced a welfare reform act, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1996. This abolished a 60-year old benefit called AFDC and replaced it with a more temporary benefit known as TANF. AFDC was abolished because it was perceived as ineffective in reducing poverty and had undermined incentives for benefit recipients to work and for families to remain intact (Montoya and Atkinson, 2002). TANF was based on the idea that all benefit recipients who can work should be in work, and recipients could only receive 60 months of the benefit in a lifetime (Montoya and Atkinson, 2002). TANF was effective in reducing the number of people on benefit – caseloads declined by 60 per cent between 1996 and 2003 (Pollack and Reuter, 2006).

PRWORA had particular implications for individuals with substance misuse problems including PDUs. It allowed states to introduce drug testing to those on benefits, to deny benefits to people convicted of drug related crimes, and to require recipients to access treatment and/or training while receiving TANF (Pollack and Reuter, 2002). These elements of conditionality were implemented to different degrees across different states.

Montoya and Atkinson published a review article in 2002 that attempted to pull together the results of studies about, or relevant to, PRWORA to comment on its potential and initial impact on substance users (Montoya and Atkinson, 2002). In particular, they examined the effectiveness of treatment for drug-using welfare recipients. They cited results from three states that found that welfare recipients who accessed treatment were more likely to find employment, including a 76 per cent increase in employment amongst TANF recipients in Florida, a 60 per cent increase in employment in California and in Kansas, they described results from a study that suggested that average income was 33 times higher than before

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<sup>3</sup> See page 3 for a fuller explanation of the reforms taking place in the UK.

treatment (Montoya and Atkinson, 2002). They also cited results from the National Treatment Outcomes Study that showed that clients attending federally funded substance abuse treatment programmes had reduced their drug use one year after leaving treatment by up to 50 per cent (CSAT 1997, cited in Montoya and Atkinson, 2002). The early effect of the reforms was not entirely positive however, and the same review highlighted the risk of increased levels of drug-related crime amongst welfare recipients who lost entitlement to their benefits through non-compliance (Reynolds *et al.* in Montoya and Atkinson, 2002).

Another study explored the extent to which the PRWORA reforms had reduced benefit uptake by low income mothers with substance misuse problems (Pollack and Reuter, 2006). The authors cited findings from the national household survey of drug abuse that found that the prevalence of substance misuse amongst benefit users was lower following the reforms than beforehand (1990 compared with 2001), perhaps because of the conditional elements. They also concluded that benefit receipt declined more quickly among illicit drug users than among non-users in the same period and that welfare recipients were more likely to report using treatment services than other low income, drug-using mothers – suggesting that the reforms had, to some degree at least, increased treatment uptake in this group (Pollack and Reuter, 2006).

A slightly different reform implemented following the changes brought in by PRWORA was the abolition from January 1997 of a specific benefit – SSI, that had previously been available only to those with substance misuse problems. An evaluation of this reform was conducted by a team of researchers located in different parts of the USA with key findings summarised in a review article by Swartz and colleagues in 2004.

Swartz and colleagues report findings from the research which followed a sample of 1,764 ex-SSI recipients (Swartz *et al.*, 2004). The study sample resided in nine different US cities. Participants were followed up at six monthly intervals from the termination of SSI until two years later. Retention rate for the study was high, with 92 per cent of participants completing three or more interviews.

SSI has previously provided recipients with around US \$500 in monthly income but also required them to participate in substance abuse treatment. Their benefit cheques were also required to be managed by a third party, usually a caseworker. Within just over two years of the SSI programme termination, between 35-43 per cent of recipients had re-qualified for different types of social security benefits such as TANF, based on other needs they had (such as physical or mental health problems), their status (i.e. a veteran) or local variation in how redetermination criteria were applied. Overall, therefore, following loss of SSI the majority of the study participants were no longer on benefits and saw their incomes fall.

The study compared outcomes between those who were able to access other benefits and those who were not (Swartz *et al.*, 2004). Those who lost SSI and were unable to replace at least half of their lost income had twice the odds of

reporting hunger and homelessness during the study period. However, rates of material hardship peaked one year after the benefit was withdrawn and thereafter improved somewhat. No significant worsening of other indicators such as psychological problems, legal problems and family conflicts were found amongst those who lost any benefit entitlement compared with others. This comparison shows that withdrawing benefits from individuals with substance misuse problems can impact on their quality of life, but perhaps less than the authors had originally anticipated.

The study also looked at participation in substance abuse treatment after termination of the benefit. SSI had required treatment participation, although it is important to note that this mandate was not fully enforced. The authors found that treatment participation rates declined quickly and sharply once SSI was terminated. More than 67 per cent of those in treatment at the start of the study had withdrawn two years later, with most drop-outs occurring within the first six months. The authors concluded that although the study could not look retrospectively at the benefits of treatment for SSI beneficiaries, it appears as though the requirement that claimants attend treatment in order to receive their benefits increased treatment participation rates above what could normally be expected. This finding is consistent with the finding noted above, that those who moved onto TANF, where treatment was also required in some states, were more likely to access this help than other low income drug users.

## 3 Client interview findings

This section of the report describes findings from interviews with 75 adults who were recruited to the study with the help of five Drug Action Teams (DATs) in England. We begin by describing the characteristics of these clients and then outline findings from a range of themes addressed in the interviews.

### 3.1 Characteristics and background

#### **Summary**

##### **Client characteristics**

The majority of respondents were in early middle age, however, this was one of only a few characteristics that they had in common. In other respects the sample was quite diverse: some respondents had no caring responsibilities or limited family connections, others were responsible for young children or had the support of an extended family. Similarly, some had stable living arrangements with no pressing financial issues, whilst others reported poor and/or temporary housing and problems covering basic expenses. The most substantial differences amongst respondents, however, related to their experiences in childhood and young adulthood. For some, drug use was just another part of an already troubled life, often involving traumatic events or a compromised childhood. However, others had a more stable upbringing and found themselves experimenting with drugs for recreational purposes.

(continued)



### Education

Respondents' accounts of their schooling tended to be fairly negative. There were many accounts of school expulsion, as well as a high prevalence of truancy. Interviewees also spoke of encountering bullying and dealing with dyslexia. It is, therefore, perhaps no surprise that most respondents left school with few qualifications. Such poor school experience, however, didn't deter some respondents from taking up training following school, with several reporting vocational qualifications. Despite the success of some respondents, though, most remained low qualified, and lacking many of the skills sought by employers.

### Employment history

It was uncommon for respondents to be in paid legal employment at the time of interviewing. Many, however, were involved in volunteering, often situated in drug and alcohol services. Respondents viewed volunteering as very beneficial, recognising the opportunities it offered for moving back into employment or simply as part of their recovery. Most had worked at some point in the past, but whilst some had enjoyed long periods in the same job or industry, others had experienced employment on a short-term and infrequent basis. There were also significant differences in the skill-set of respondents and therefore the types of jobs they achieved. Certain interviewees had advanced work-related knowledge and skills which meant they had experienced responsible and challenging employment. In contrast, other respondents possessed few vocational skills which confined them to unskilled jobs. Finally, the mixture of experience exhibited by respondents was also demonstrated in terms of post-school employment. Some interviewees encountered no problems in obtaining employment following leaving school, but others faced long periods of unemployment.

### Drug use history

Many of the interviewees had a long history of drug misuse, with most beginning during their teens whilst still at school. These respondents typically began smoking cannabis with friends, moving on to harder drugs such as heroin and crack cocaine in later years. Other drugs used by respondents included cocaine, amphetamines, ecstasy and LSD. For some, their drug use was complicated by using drugs intravenously or accompanying alcohol use. Most respondents reported the impact of certain crises such as the threat of losing their home as causing them to realise that their drug use had become problematic. In terms of treatment, many respondents had extensive experience of accessing support to address their drug use, with some reporting relapse following long periods of recovery.

### 3.1.1 Client characteristics

In this section, basic characteristics of the interview respondents are reviewed alongside a summary of their housing and financial issues. Respondents' accounts of their background are also briefly discussed.

In terms of age, the 75 interview respondents ranged from 22 to 65. However, most were in their 30s or 40s. In terms of caring responsibilities, some interviewees had young children, though not all had responsibility for these children. In many cases, such interviewees did not share a home with their child or children. Few respondents reported that they supported elderly or disabled relatives.

Some respondents did not have a wide social network, but many others talked of ongoing relationships with partners and extended families, including grown-up children, parents, brothers, sisters and even grandparents. Some respondents described how supportive their families had been and credited them with getting them through difficult periods in their lives. According to one interviewee:

*'I've got a good family. If I hadn't got a good family, by me, I wouldn't have got by. My sister cooks for me and my mum cooks for me. People who don't have family around them, they'd have to think of something.'*

The types of accommodation in which respondents lived varied. Some lived in stable rented homes obtained from the public or private sector, whilst others lived in temporary accommodation such as a hostel, or with friends and relatives. A number of interviewees mentioned previous homelessness, living rough on the street. Some interviewees who lived in rented accommodation mentioned problems with their housing. Asked about his current housing situation, one interviewee responded:

*'It's a bit fidgety at the minute because we've got a landlord who's not the best landlord in the world,...All the jobs in the house that need doing, he's required to do them and he's not been along. And if it weren't for the fact that I'd done the jobs it wouldn't be, you couldn't live there. It would be uninhabitable, you could not live there. No radiators coming on in the middle of winter, it's no good! Especially with kids in the house and that. And its cr\*p windows and faulty electrics.'*

Problems with housing in some cases related to financial difficulties. In one example, a female respondent discussed the possibility of losing her home.

*'I'm about to lose my house...I'm behind on the rent 'cos they want it weekly and 'cos we get our Housing Benefit monthly, they want £500 on top of the £500 a month. ...we tried to get another place, but because we're renting the council won't help and I couldn't get another private place because of the rent.'*

Several respondents also talked about their drug use resulting in substantial debt, which, in the case of some respondents, they were still paying off. For some, debt problems were part of a generally poor financial situation, as illustrated by the following respondent who received Income Support (IS).

*'...because this is my first year of claiming I'm only allowed £60 a week even though I've still got to follow all the rules, which I think is ridiculous, to be honest. There should be certain circumstances, I would have thought. I end up going without food because it's just that tight...I've got to pay all my bills like gas and electric, food, credit card, gym membership etc out of there. I owe the rehab money...'*

A female respondent, who described being very careful with her income, also discussed her financial problems.

*'I'm trying to budget everything but I'm giving so much over to where I'm living, that there's not a lot left. It's really hard because you're given with one hand and now I've got to pay rent and everything, I'm giving so much to that. It's really hard.'*

However, although this woman also felt she had very little to live on, she didn't think extra money would be beneficial in case it led her to relapse into drug use. Instead, the interviewee said she would like to receive food vouchers to improve her health and standard of living.

Although many respondents talked of experiencing stable childhoods, there were others whose lives had been characterised by severe problems and traumatic events. These included poverty, domestic violence, physical and sexual abuse, parental addiction and absence, as well as general instability. Some individuals had also spent time in care. One interviewee described a particularly unsettled childhood:

*'At the age of seven my mum put me in a children's home and I bounced from home to home and then the last one was in xxxx and it closed down so I got foster parents and I didn't like them so I ran away from them to my real mum's and I just stayed with her after that. I was in care from the age of 7 til the age of 16.'*

Another respondent discussed her family's involvement in crime and her initiation into that world:

*'...my family were criminal minded...we were shown from a very young age how to commit fraud, how to do all sorts of stuff...So, after school, it was like a natural thing for me to kind of...become a thief.'*

In adulthood, some respondents faced further, similar problems. A number of female interviewees spoke of being a victim of domestic abuse and the impact it had on their lives. When asked about receiving any education following leaving school, one woman replied:

*'I tried, but I was in a domestic violence relationship and I didn't have control. I got on courses but something would always happen so I couldn't turn up to the course.'*

Another traumatic event highlighted by a male interviewee, was a serious assault by two other men which left him with severe injuries:

*'About three year ago, I was in intensive care and that's why I'm like I am now, I've got brain damage...it took me two and a half, three years to learn to talk and walk properly again.'*

### 3.1.2 Education

Interviewees were asked about their experiences of school, and talked about their attendance, difficulties they had whilst there, qualifications gained and whether they received any education or training after leaving school.

#### *School attendance*

All of the respondents were asked what age they were on leaving school and the circumstances in which they left school. The majority of interviewees reported leaving school at the age of 15 or 16 years old, with some reporting that they left at the age of 14 years and others staying on until they were 17. Of those leaving school early, some made this choice themselves. One other interviewee left school as a result of becoming pregnant and the remaining respondents left early because they had been expelled from school. Within this group there were some whose expulsion marked the end of their secondary education. In some cases this expulsion was the final one in a series of previous expulsions and no other school was willing to take them:

*'I got suspended and kicked out of every school I went to.'*

*'They didn't want me in the school for the last two years, from when I was 14 to when I was 16, 'cos they got a group that was about 25 or 30 of us from our year and they said "we don't want you in the school anymore. No school's really going to take you".'*

Other interviewees who had been excluded from school spoke about being sent to either boarding school or a school that specialised in 'dysfunctional children'. Some in this group spoke of this move away from mainstream school positively:

*'I didn't like being in secondary school, with there being so many people in the class, so I started misbehaving and got put in a special school where there was only five people per class. I settled in there and done well getting a distinction...'*

Many of the respondents who left school early but were not expelled spoke about a pattern of frequent truanting that often ended in the respondent not going back to school:

*'We weren't expelled. We just didn't turn up at school. My mum and dad never made me go from about the age of 14 and I could just do what I wanted.'*

*'I left school when I was 15, and that was around when I was supposed to be taking my O levels, I just didn't turn up for anything.'*

In fact, truanting from school was a recurrent theme in many of the interviews regardless of when the respondents left school:

*'I had no problem at school, just a normal [child]. I played truant a lot. Bored with it actually. I was learning more going down the museums than what I was learning at school.'*

*'I spent my last two years at school playing pool, smoking weed.'*

#### *Difficulties whilst at school*

Some respondents spoke of their unhappiness when at school. Many were victims of bullying whilst there or felt excluded from their peer groups:

*'I had quite a lot of bullies when I was a kid...you know, falling back on lessons because of bullying and when I was falling back on the lessons I'd have to go into different lessons, so I was being bullied for that as well.'*

*'I didn't really like school. I was always nipping off because I used to get bullied when I was at school.'*

*'I didn't really like school. You had the cool kids and I wasn't one of them...I didn't really learn very much at school because I didn't like it...I did my GCSEs. I didn't get good grades, though.'*

There were also some respondents who mentioned having dyslexia, associating this with problems they experienced while at school:

*'I suffered at school because I'm dyslexic, but it wasn't recognised in my day and I was just always thought of as stupid, or backwards.'*

*'I was dyslexic, I was always put in the special needs class, school was s\*\*t.'*

Another strong theme to emerge was the influence of respondents' peers on their behaviour in school. There was recognition amongst these respondents that their choice of friends had had a negative impact on their attendance at school:

*'I never really got on with the other kids. I struggled to make friends with people...I always wanted a bunch of people to accept me and I remember the people who were faffing about, they were the kind of people who accepted me so that's how it started really.'*

*'I suppose I was mixing with the wrong sort of people, if they didn't want to go into school I didn't go in and I'd doss around.'*

### *Qualifications gained at school*

The highest level of qualification gained in school by the vast majority of respondents was O level or GCSE level. However, one respondent did go on to achieve A levels at college. Those who did sit GCSEs or O levels reported varying success:

*'...I did alright. Quite well, eight GCSEs.'*

*'I left school in 1988 at 16. School was okay...I could have done a lot better...I got Cs, Ds and Es [in my] GCSEs.'*

Most interviewees, however, left school with no qualifications, some having left before sitting their exams:

*'I didn't pass any exams. I did school but I only did up to fourth year. I was in the fourth year. I didn't do the last year but I got expelled...'*

*'I got kicked out at primary school and put into boarding school, but I enjoyed it there...I didn't really work so I couldn't take my qualifications, GCSEs and all that. I went to prison and I couldn't take anything in prison.'*

Most worryingly was one respondent who said that he left school while still having problems reading and writing. He spoke of the problems it causes to this day:

*'It adds to problems later on, because of my reading and writing, I mean, going for jobs and stuff is very difficult, because I already see myself as below par and if I need to compete, I need to be up to par, you know what I mean.'*

### *Education and training following school*

Some of the respondents spoke about taking training or education courses after leaving secondary school, though not all of them gave details of what, if any, qualifications they gained from them:

*'I came here to use computers and they had a mentoring course, and I started here on mentoring, then after mentoring, I did a life skills course, class where they teach life skills, and then I got on a exercise programme. So I was developing as I went along.'*

Some respondents were more specific and spoke about sitting GCSEs (or equivalent level exams) for the first time at college or whilst in prison; and some also spoke of re-sitting them. Many spoke about taking vocational qualifications such as National Vocational Qualifications (NVQs), Higher National Certificates (HNCs) or BTECs, again either in college or in prison. The most popular qualifications taken amongst respondents were related to catering but other qualifications mentioned included those in sport and recreation, leisure and tourism, business and finance, and IT.

Some interviewees spoke about whether they made use of their qualifications to gain employment. One respondent talked about not using his mechanics or cheffing qualifications to find related work:

*'I passed my motor mechanics and stuff like that. And cheffing. But I didn't really, I don't know, because I wasn't really interested in anything. I passed them both and then that was it, it was like it was done then so I don't know, you know. I wouldn't have been able to afford it because my son was born then and I wouldn't have been able to afford an apprenticeship at that time.'*

However, another respondent talked about taking a number of courses in order to qualify as a chef and then entering into the catering business.

### 3.1.3 Employment history

Within this section, we examine the employment experience of the clients we interviewed. First, we look at their current involvement in paid work and volunteering, before moving on to consider work history, including the types of jobs respondents have held in the past. Finally, the nature of respondents' post-school employment is outlined.

#### *Current employment and voluntary work*

Most respondents were not in legal paid employment at the time of the study. Of those exceptional few who were, most held positions in services that provide support to people with drug or alcohol problems. Of the remainder, one individual was self-employed as a builder; whilst another worked as a cashier in a supermarket. All of the respondents who were legally employed had either overcome their drug use problems or were stabilised on a substitute prescription.

Many of those respondents not in legal paid employment were engaged in voluntary work. Most commonly, such voluntary work, similar to the paid employment discussed above, involved supporting other people with drug and alcohol problems. Some respondents discussed the benefits of being involved in voluntary work. For certain interviewees, voluntary work was viewed as a good way of getting back into employment. One participant, hoped to get back into employment very soon by combining training, practical experience and voluntary work.

*'I'm on an NVQ placement as well, so voluntary and placement is kind of combined. My placement I need to do 16 hours a week...so I manage to cover that...and combine it with my NVQ and voluntary work combined because that's where I'm hoping to end up in employment. So I'm getting the practical experience, doing the theory side, and it's working out quite well.'*

Alternatively, other interviewees viewed voluntary work as part of their recovery, giving them confidence and occupying their time:

*'They run a group here on a Thursday and I've been going there and there's two places coming up on the course for voluntary work so I've put me name down for that so I'll see if I can get out of the house that way. It's all voluntary.'*

This was particularly the case for one of the older interview respondents, who had a long history of alcohol abuse. The interviewee, who felt he would never work again due to ongoing physical problems and anxiety, said voluntary work provided the opportunity to improve self-confidence and also give something back to society. The interviewee also spoke of how voluntary work gave him the opportunity to participate without the demands of paid employment.

*'From my own point of view...I'm afraid to do it full-time, would be a lot different. I wouldn't feel as confident if it was actually a paid job. I'm afraid that then all the anxiety and all the worries would come back. They are actually there when you're volunteering but you keep it, you minimise it, you know what I mean. You are not getting yourself into a situation where you can't get out of it.'*

### *Reasons for leaving last job*

For those study respondents who were not working at the time of interview, there were a number of reasons why they had left their last paid job. Many disclosed ongoing drug use as the reason behind leaving their last job. In some cases, this was due to respondents not being able to cope with the job. One individual described how they didn't feel comfortable continuing in the job they were in, due to their problems with drugs.

*'I was banking the money every week and I had the combination to the safe. A drug addict around that type of money is not a good mix, you know. So, I couldn't trust myself to do it.'*

Others, however, described how they had been sacked from their last job because their employers were unable to tolerate their drug use and its resultant effects of their behaviour and reliability.

*'I was working in an Italian restaurant just outside of xxxx. That was a nice job I was sacked. Yeah. Through the drink and the drugs. That was about four years ago.'*

*'...my employers had to let me go. "You know, you're a great worker, and all the rest of it, when you're here, but your behaviour's just not conducive to your job".'*

Less commonly respondents described being sacked due to activities related to their drug use, such as theft from their place of work.



*'I got on the heroin and ended up taking money and that's how I lost my job there...I had a good job, really, if I hadn't got involved with the drugs.'*

Although some respondents had to leave their last job due to drug use, many others provided a variety of different reasons for leaving their last job. In some cases, this was again due to negative behaviour in the workplace. In particular, some interviewees were sacked for becoming involved in violence at work. Others were forced to leave because of circumstances beyond their control, including ill-health and a downturn in their employer's business.

### *Work history*

Most interviewees had been employed in the past, and those with no previous work experience were the exception. Many of those with a history of work discussed long periods of uninterrupted employment lasting, in some instances, decades. A male respondent, who disclosed current heroin use and had received Incapacity Benefit (IB) for five months, outlined the time he'd spent working in the construction industry.

*'I've been self-employed for the past five years...I've worked the majority of my adult life. Even though I've been using, I've normally always worked. Building trade at the moment is almost dead, so roofing, that's what my trade is, I'm a qualified roofer. It's a nightmare at the moment, working out there.'*

Moreover, another male interviewee, with a history of primarily alcohol rather than drug abuse, spoke of working in IT for almost 20 years.

*'I've worked in IT for 18 years and therefore, I've done a lot of courses and qualifications in that field, through work. Much of which is bespoke. ...so I can apply myself when I put my mind to it.'*

In contrast, other respondents with a history of employment described short-lived and irregular periods of employment:

*'My last job was in 1996...I've never been able to hold a job down. I don't think I'm a job person.'*

*'My jobs were brief. My time not signing on – a month at most.'*

*'I've done a few bits of work. I'm never constant in work, though.'*

With regard to the types of jobs interviewees had been involved in, as partly highlighted previously, this ranged from being highly skilled to very low skilled. Reference to more highly skilled jobs mainly related to trades such as joinery and plastering and also hairdressing, although one man reported working as a building surveyor. Semi-skilled and low skilled jobs mentioned within interviews included administration, retailing, tele-sales, cleaning, bar work, and labouring.

### *Post-school employment*

Similar to previous sections, respondents reported a mixture of experiences with regard to post-school employment. Some interviewees left school and went into work or training either immediately or soon after leaving school.

*'I went into a job straight away, literally. I finished school on the Friday and started working on the Monday.'*

*'...I stayed with my mum and dad and went and did hairdressing for a year and a half...and then I got a shop job and I stayed there for about five years...I've worked from being 16.'*

*I started a four-year apprenticeship when I was about 15 years old in landscape gardening.'*

Other interviewees struggled to find employment after school, some having long periods of unemployment. One respondent mentioned being unemployed for three years following leaving school.

*'I was out of work for three years. Not having any qualifications and there was nothing that I could do. No-one would take me at the time, so I just had to go without a job.'*

### **3.1.4 Drug use history**

This section discusses the findings relating to respondents' drug-using history. It touches on a number of themes including: initiation of drug use, experience of treatment, relapse and other issues surrounding drug use. Though the focus of this study was problematic drug users (PDUs), it is important to note that a very small number of respondents interviewed were primarily alcohol users or users of drugs other than opiates or crack cocaine. Rather than exclude the experiences of this group, the research team decided to include the valuable information provided, due to the similarity of their experiences to those of the PDUs.

#### *Beginning drug use*

Respondents' experiences of beginning to use drugs can be divided into three main groups. Most interviewees began using drugs in their early to mid-teens, another group began using at a later stage and a third, less common group was introduced to drugs before reaching adolescence.

Most of those interviewed had their first experiences with drugs when at school. Many mentioned school friends smoking cannabis or using solvents as their introduction to drug use.

*'I started around school time, really, you know, the last year in school was when I was smoking a bit of cannabis.'*

*'The aerosols, while I was at school. The pot at lunchtime, if I was at school and drinking at the weekends at the time.'*

Some interviewees said that their drug use began when they were older and had left school. Of these, a number of them had been introduced to drugs by their partners:

*'I got involved with drugs a bit later, about 18, that's when I started getting involved with drugs, when I quit the hairdressing...I was going out with this man that asked if I wanted to try it, and I tried it and I liked the taste of it.'*

*'My child's father started forcing me into it, I argued till I was blue in the face that I didn't want any, I eventually gave in to temptation.'*

For others their drug use coincided with the death of a sibling or child:

*'We lost Dominic, one [brother] that's down from me, to drink.'*

*'When I lost the baby, I just started going out, being self-destructive, um, for a month I was just in such a deep depression I laid on the sofa. I tried counselling, I don't think I was ready for counselling at the time and I just felt like going out, taking ecstasy, speed, drink, anything.'*

The remaining respondents were introduced to drugs at a very early age. Some had siblings that were already using drugs:

*'From the age of seven onwards. I had an older brother and he was on the drugs when I was younger. He got me into them.'*

*'I was pretty heavy into cannabis at school...I started cannabis at eight years old. Many brothers, I'm the second to the last and they all smoked it, it was in an ashtray right next to them and I saw it and I took it.'*

Others linked the beginning of their drug use to being placed in care:

*'I started when I was ten when I went to a kids' home.'*

*'I didn't smoke, didn't drink, didn't do anything. No vices until I went into the children's home. Then I started smoking cannabis. That lasted for about five years and then it escalated.'*

One interviewee said they started drinking and using solvents in response to their unstable home environment:

*'When I was about 12, 13. I was in a mad situation at home and there was a lot of violence. I'd be sniffing glue, tippex, drinking, before that; from about five, seven, I'd been drinking to escape the reality of my home life.'*

### *Drugs used*

Poly-drug use was a feature of the sample interviewed and the majority of respondents had used a number of drugs such as; heroin, crack cocaine, cocaine and cannabis.

*'I was using crack cocaine. I dabbled with heroin. I used cocaine, I used MDMA, I used ecstasy, I used marijuana, I used hashish, I used amphetamines, I used alcohol.'*

*'Everything from cannabis to crack cocaine.'*

Other drugs used by respondents included: amphetamines, ecstasy and LSD or other hallucinogens.

*'Amphetamine – that was the main one – and pills and cocaine. In the younger days we experimented with them all: magic mushrooms, acid, cannabis, aerosols.'*

Most interviewees when starting to take drugs did not immediately use substances like heroin or crack cocaine. It was common for respondents to describe using solvents or cannabis along with alcohol at an early age; then progressing to heroin and/or crack cocaine as they got older.

*'I did start on cannabis, and then I went from cannabis to coke and now I'm on heroin.'*

*'I started smoking cannabis at about 13, no, about 12, and then I stopped and then I started going out drinking and taking ecstasy and that when I was about 15 and then I got with my partner and he was on heroin and crack and I'd been with him about six months and then I started taking it...I just kept seeing him doing it all the time.'*

There were, however, some exceptions to this:

*'Just started using heroin instead of booze. I used to hang around people who'd do a little clubbing and so be using ecstasy and heroin was a delicious way of coming down from that.'*

### *Injecting*

As previously mentioned the majority of interviewees used class A drugs such as heroin and crack cocaine. It was not uncommon for respondents to admit to injecting heroin. All of the injectors began smoking the drug but as their addiction to heroin progressed, they began injecting.

*'I used to smoke at the beginning, and then the heroin that was about became unfit to smoke so you had to inject it, so consequently I then went on to injecting. One thing led to another, really.'*

Similar to other research with injectors the respondents in this study mentioned some of the health problems associated with this type of drug use. The majority of them had experienced problems with collapsed veins or abscesses and a number of them suffered from deep vein thrombosis (DVT) due to frequent injecting.

*'So I've been injecting from about 21 up until I'd say about a year ago. A year and a half ago. But I started injecting in my arms at first, and then I lost all my veins, they just collapsed. Then I started in my femoral artery and I ended up with DVT and ended up in hospital twice.'*

Some interviewees revealed that they were positive for hepatitis C and that their injecting drug use was the route of transmission.

### *Alcohol use*

Alcohol use was very common and referred to by nearly all interviewees. In most cases alcohol pre-dated or accompanied their drug use. When asked about their drug use history and when they began using illegal substances, alcohol and drugs were mentioned together.

*'Yeah, I started drinking and sniffing gas and stuff like that when I was 12 and taking magic mushrooms and LSD and stuff like that, smoking cannabis.'*

*'I started drinking at an early age. Didn't start using drugs until I was in my early 20s and I started on pot, weed, once in a blue moon I'd have a smoke and that progressively became more and more.'*

In general, most respondents did not see their alcohol use as problematic, though this was not always the case. In one area, nearly all interviewees identified their alcohol use as problematic.

*'I would start drinking in the morning, just because getting into the day was difficult without drinking, partly because you felt so ill from the night before but also just to give you the balls to get stuck in to what you had to do.'*

*'I dressed it up to the extent that it was a marriage breakdown. It was a marriage breakdown because of the alcohol abuse.'*

Further interviewees, in another study site, also referred to problematic use of alcohol.

*'Because I was homeless I would deliberately drink myself stupid so that I could do so much damage to my pancreas that I would have to go into the hospital.'*

*'I tended to hit the drink a lot to cope with it because it sends you to a really bad mental state, you get paranoid about everything and the drink took that away.'*

### *Realising drug use had become a problem*

For many respondents the realisation that their drug use was problematic generally coincided with external pressures or crises. Some of those interviewed mentioned becoming aware of their problematic use only when there was a possibility they could lose their home or, as in one case, when they did lose their home.

*'I had to sell my house because I was heavily in debt. It would have been taken anyway.'*

For one interviewee, focusing on their children made them realise they had a problem. Another interviewee who was sent to prison said his mother's reaction helped him to realise he had a problem:

*'My mum broke down over the phone. She said "oh, what's happening to my grandkids" and all the rest of it and my mum's never really cried because I've never made her cry for anything. And when she broke down in tears and all that, it just stung me. It really, really stung me.'*

### *Experience of treatment*

All of those interviewed had some experience of substance misuse treatment. Only some respondents said that the agency they were currently attending was their first experience of treatment. The majority of the sample were being prescribed methadone or had at some point been in receipt of methadone as part of their treatment. It was common for those on methadone to describe 'topping up' their prescription with heroin. Other respondents mentioned being prescribed another opiate substitute: subutex.

*'Well, I still do. I use heroin. I mean I'm on a methadone programme, but, you know, one does use on top of that.'*

Nearly the entire sample reported attending a treatment agency which provided them with a key worker and coordinated access to other related services such as counselling, group work and health care. They were referred to these agencies by various routes. Many were referred through criminal justice drug interventions, others were referred by their GP and another group found services through friends who were already attending them. Some mentioned how their recovery was aided by attending these agencies on an almost daily basis.

*'I mean, xxxx [treatment agency] has got a five-days-a-week structured daycare programme, so when you go in the morning there's something that you can do all day to keep yourself busy and take your mind off things.'*

For the majority of respondents, attendance at these agencies was not their first experience of treatment. They often arrived at the agencies after attempts at detoxification or stints in residential rehabilitation were unsuccessful.

*‘The first time I went into detox I did it more for the family. Then I came out and I thought “I could dabble again and never get hooked”. And I did. Then I went into detox again, recovered, then three or four months later something happened and I started using again.’*

Some of those interviewed mentioned relapsing. There were three main reasons given for relapse. Some felt it was caused by returning from residential rehab or prison to the same area and temptations as before. Others said it was triggered by a personal crisis such as a bereavement or relationship breakdown and some felt that they weren’t ready to stop using at that time.

*‘No. I used one time, one evening, and then I went back to xxxx [rehabilitation unit] the next day and I felt so guilty that I left and I started again. Obviously I wasn’t ready.’*

Another type of agency mentioned by some respondents was Alcoholics Anonymous and its corresponding drug service Narcotics Anonymous. Many found the regular meetings and access to a sponsor helpful to their recovery.

*‘Cocaine Anonymous. And like I said, they’re 24-7, these people. The phone runs 24-7. Meetings are on morning, noon and night and even if you go to a 24-hour residential rehab, they’re only six months, three months, depending on your funding. Whereas NA, CA, they’re 24-7 year in, year out. And they don’t care about money, it’s about helping.’*

3.2      The benefit system and Jobcentre Plus

**Summary**

**Claiming and receiving benefit**

All of the respondents were either currently in receipt of benefits or had received them in the past. Some received IB (or Employment and Support Allowance (ESA)) due to poor mental or physical health and addiction, but others were receiving Jobseekers’ Allowance (JSA). Despite being on similar benefits, interviewees’ experiences of the benefit system were varied. Some respondents described applying for benefits as straightforward and Jobcentre Plus staff as positive and helpful. Others had had more problematic experiences and described, in detail, the problems they encountered during their medical examinations and capability assessments. Furthermore, some interviewees provided examples of administrative mistakes and delays and highlighted how these had affected their lives and their efforts to make the transition from benefits to work.

(continued)

### **Barriers to benefit uptake**

A number of barriers to claiming benefits were highlighted during the interviews. These included a lack of knowledge regarding benefit entitlement and a lack of easily available advice on this issue; difficulties with requirements to fill out application forms and attend appointments; and problems with the facilities used by Jobcentre Plus to handle client enquiries and consultations. Further barriers encountered related to respondents' relationship with staff working within Jobcentre Plus. Some respondents described feeling stigmatised by workers, whilst others said they felt they had to behave in a certain way in order to receive help.

### **Looking for employment through Jobcentre Plus**

Some respondents encountered problems in matching their employment expectations to the type of jobs promoted by Jobcentre Plus, and felt that the jobs advertised lacked relevance to their particular skills, or lacked prospects. Others expressed negative views about Jobcentre Plus staff's understanding of their circumstances in relation to their ability to work, with particular reference to their methadone prescriptions. Respondents felt that Jobcentre Plus could do more to help customers like them find employment, including providing more encouragement to apply for jobs, ensuring they follow up opportunities and offering more gradual paths back into employment.

## **3.2.1 Claiming and receiving benefit**

This section summarises respondents' experiences of claiming and receiving benefit, and in doing so highlights both negative and positive experiences. After first describing respondents' current and previous benefit claims the section looks at their experiences of supportive Jobcentre Plus staff, before moving on to explore elements of the claiming process which some respondents have found problematic and negative. It ends with a discussion of the impact of mistakes and delays in the administration and payment of benefits on the lives of respondents. Particular emphasis in this section is placed on areas where improvements can be made which would benefit PDUs.

### *Current and previous benefit receipt*

All of the respondents interviewed were either currently receiving benefits or had received benefits in the past. The current out-of-work benefits received by respondents included IB, IS, JSA; and ESA. Other benefits received included Disability Living Allowance (DLA) and Carer's Allowance (CA). A number of interviewees also mentioned receiving Child Benefit and Working Families' Tax Credit; Housing Benefit, the State Pension and Statutory Sick Pay.

The majority of respondents were receiving out-of-work benefits, with IS, IB and JSA being most common. Some interviewees reported claiming the new ESA.



Claims for sickness benefits were largely due to mental health problems such as anxiety and depression and in some cases schizophrenia and post-traumatic stress disorder. Some respondents also attributed their claims to ongoing recovery from drug use.

Information provided by respondents on past benefit receipt proved patchy, with many respondents not disclosing previously claimed benefits. Considering the responses of those who did mention their past receipt there was one interesting pattern. Most of the respondents currently claiming IB or ESA had previously claimed JSA. In contrast, there was no one benefit that was particularly common to the previous benefit history of those respondents now receiving JSA or IS.

For many interviewees it seemed that the suggestion to claim their current benefit originally came from their GP. Other interviewees mentioned the support of other sectors such as the probation service, whilst some said that they thought of applying themselves or were recommended by a friend or relative.

#### *Positive reports of supportive staff*

A significant number of respondents reported no difficulties in relation to contact with Jobcentre Plus. They had not experienced any problems applying for benefits nor had they any complaints about staff working within Jobcentre Plus.

*'I've got to say, my experiences, which have been quite a lot recently, both actually talking to people on the telephone and talking to people, writing to people, getting letters back, I've actually found them really helpful and I've found everybody that I've dealt with to be surprisingly, or, I've been surprised, I've found them surprisingly non-obstructive.'*

Some respondents described how helpful Jobcentre Plus staff had been in relation to looking for employment.

*'They are helpful 'cos they are also looking for jobs for you. They've got the computers, they have a look for you, see if there's any jobs for you. They're actually quite helpful...'*

*'They always go on the computer and that for me, and say "there's this job coming up" or whatever, and they give me application forms but they don't, they don't look at me any different just because I use drugs...they help me if I need help and that, if I ask for it.'*

Several other respondents expressed great satisfaction with the support they had received from benefit officials who were helpful and understanding of their situation.

*'My Pathway's adviser, she's good. She lets me do things at my own pace, she says I'm not ready to start looking towards getting back in to work. She won't force me into it. You can't ask fairer than that.'*

*'He was going to go through a set pattern of questions and I said, "I might be able to save you some time, here; I've just got out of treatment" and he said, "oh, well, in that case..." and I said "well, I'm in college and I'm trying this" and he said he just wanted to let me know that there's a lot of help here for when I do want to go to work...he was really, really helpful...he did seem very clued up.'*

#### *Claiming benefit: medical examinations and capability assessments*

Some respondents, however, had had negative experiences of the benefit system and Jobcentre Plus. A major issue that arose in discussions with interviewees related to disagreements with Jobcentre Plus over their ability to work. Respondents who had been receiving benefits due to health reasons talked of feeling pressured into moving off these benefits and on to JSA to prepare for employment. In such situations, respondents spoke of not feeling ready to work due to ongoing addiction. This was also true of many respondents who were keen to return to work in the near future:

*'When I lost my children I went on Jobseeker's for about three years, four years and then I went on Incapacity Benefit for about two years, then they decided that I was fit enough to go back to work. I was rather annoyed because even though I'm desperate to go back to work I still feel that I am not fit because I'm having to rely on the subutex [substitute medication].'*

*'I was on the sick for a bit and they told me that they wanted me to come off the sick. I was saying to them, "well, I'm still in the same position I was in a year or so ago, I'm still depressed, I'm still on drugs, I've still got care taken of me" and so they suspended my sick money and they wanted me to come off it.'*

*'If I'm on Incapacity and I'm not ready to work, they should still be giving me some kind of help and assistance in getting me forward to that rather than sticking me on f\*\*\*ing Jobseeker's Allowance and then having to go and do it [sign on, look for work, etc.]... 'cos that just puts more on your plate....I'm that scared in case I f\*\*k up...I know I shouldn't f\*\*\*ing need it but I do.'*

Interviewees also described their experience of medical assessments examining their work capability, and expressed how they felt the process did not satisfy their expectations or needs. Some discussed how they felt that the examination process was not sensitive to their individual situations:

*'...they asked me questions like "can you stand up?" "Can you sit down?" "Can you reliably answer the phone and take a message?" And they said, "how are you feeling?" And I said, "I'm fine, but I'm feeling okay because I'm engaged with the xxxx [treatment agency] and I'm surrounded by people in recovery every day..." So, a lot of my answers were falling into a grey area and there aren't any grey areas on that form. It's all 'yes' or 'no' boxes. So, because I was okay sitting in the xxxx [treatment agency]...I was well enough to go to work. And that caused me a lot of problems because I was still in treatment ...'*

*'...my adviser...she said I should go on the sick...I went for the medical and they sent it back saying that I could work...I felt bad, to be honest, pretty low, but I'm on antidepressants as it is. They complain if you're honest, though, if you're honest with them, you try to be honest like you say "I've good and bad days" and they say "okay, then, on the good days you can work".'*

Another interviewee described how he had experienced inconsistency in the approach of professionals carrying out medical examinations. The respondent described how, in a recent medical examination, he felt the process was rushed and his circumstances were not fully taken into account. The respondent contrasted this experience with that of an earlier medical where he felt the professional dealing with his case had taken the time to consider his case more carefully:

*'It was a very frustrating interview which was really short and it was a real contrast to the last time this happened. ...the questions were so obviously tick box questions, there was no room for interpretation apart from her interpretation of being 'yes' or 'no'...This last time I was there for about ten minutes. The time before that I was there for a good 40 minutes, and the guy was just generally interested. He was far more probing, far more empathetic... and I felt his decision, whatever it was that he arrived at, had been carefully considered and in no way did I consider it to be, on this last one.'*

The respondent also went on to describe how he felt he had been too honest with the most recent medical examiner regarding his capabilities.

*'...what I tried to do was to pitch the whole thing as honestly as possible...I said I'd been doing voluntary work, which I have been doing...And physically, I'm feeling okay, you know and basically my problems are I don't go out, don't answer the phone five days in a row, I don't speak to anybody for five days in a row. I can't. When I'm down, it's like the house could be on fire, you know, it doesn't make a lot of difference.'*

A further female interviewee expressed how she felt that medical examinations were designed to focus upon an individual's physical disabilities, with little scope for highlighting other issues:

*'They've sent me my medical and you know, it's a point system. Well, it was all geared to people with disability mobility. And it was very, very difficult to answer the questions that they wanted you to answer, around mental health problems, especially addiction.'*

According to the interviewee, the medical professional who led her last examination shared her concerns regarding the inappropriateness of the forms she was using.

*'The lady that was doing the actual medical with me, she actually said after we did it, you know, 'cos I said to her, "this is very difficult. There's nothing there to tell them where I'm at." And she said, "no". What I've got to try and do is put over to them that you could do with more time. But how I'm actually going to actually do this I don't know.'*

Another respondent expressed how he found regular medical examinations stressful due to the fear of losing his benefits, which he believed could lead to relapse into drug use.

*'I still have to go through reviews now. Of course, say every few months they send me a form that I have to fill in to justify why I'm on Income Support, so I've got to go and get a doctor's note and I've got to go and tell them and I've got one tomorrow. I've got to go to medical services tomorrow...I feel that I'm trying to work towards a better life for myself and it seems like they keep trying to pull the rope out from under me. It's not that I want to be on benefits, but at the moment, it's a necessity for what I'm trying to do. And of course, I'm scared of what's going to happen if I can't pay my simple bills, you know. That's going to cause me to feel so bad that I might have to go back out there [and start using drugs again], you know, and I don't want that. Not at all.'*

Echoing the fears of the previous interviewee, a female respondent, who was involved in both alcohol and drug abuse, described the experience of losing her claim to IB and making the transition to JSA. The interviewee discussed how difficult she found this situation, especially at such an early stage of her recovery and credited her key worker, based at a local support agency, with helping her to cope with the changes. Without such support, the respondent said she believes she would have returned to substance abuse.

*'...last November I went for a medical and went through the medical and then in January I heard that I had to go onto Jobseeker's, but it was only September I came out of the detox, so I was only three and a half months sober, so you can imagine how that threw me. Not only that but because I'd lost the top-up money, I couldn't pay the rent, which had just gone up as well, so I was dealing with housing and all the Jobseeker's stuff coming off one benefit onto another and the stress and everything that causes, I mean, it was like a minefield. Every day there was different documents coming through the door and if I didn't have the [support agency] and my key worker and the meetings, I know I would have used, definitely.'*

### *Mistakes, delays and financial problems*

When discussing their experience of the benefit system, a number of interviewees talked about the impact on their lives of what they described as mistakes made by Jobcentre Plus. One respondent said they had been threatened with eviction from their council home because of poor communication between official departments.

*'...when I first applied for Income Support they got it all messed up and that, and it was their mistake, 'cos I filled all my forms in and I got a letter through off the Council saying I was getting kicked 'cos my Housing Benefit hadn't been paid and I tried to explain that it was all coming from the Social blah blah blah, and it took a couple of weeks for them to realise it was just a mistake and I did get it backdated, so it wasn't the fact that I couldn't have it, they'd just made a mistake.'*

Another respondent talked about an administrative mistake that meant he lost his benefits for many months.

*'I had a claim going and I stopped claiming because there was a mess up with my sick notes and I was out of benefits for nine months. It's only through the probation service that I ended up with any money again.'*

Other respondents described problems with long delays in the processing of benefit claims. One interviewee discussed the financial difficulties he encountered while waiting for a decision on his claim for IB. The respondent explained that in the meantime, he received money from a crisis loan, which meant that he then owed a substantial amount to Jobcentre Plus. Asked about the transition from JSA to IB, the respondent replied:

*'Yeah, because you've got to wait – you'll get your final payment of Jobseeker's and it could be seven weeks before you get another payment. So you rely on crisis funding and now I owe them over a grand and a half. I think I've paid about £200 off. So, and that was mainly because I couldn't afford to live. I couldn't afford to survive. It was either that or go out working and the choice was to get myself in debt rather than go out working somewhere.'*

A further interviewee talked about problems with resuming his claim to IB after time in prison. Prior to going into prison, the respondent said he had been receiving IB for an indefinite period of time. On leaving prison he found he had to appeal his benefit claim, similar to an earlier situation.

*'...before I went to prison, I had been signed on the sick for life. And with us going to prison, that stopped and when I got out of prison, I [was] put back in for it and I've got to go through all of this again, because this happened two or three years ago and I had to appeal against it. And I won the appeal, and I got nearly £1,200 backdated through not being paid the right money, so hopefully, with that happening, it will happen again and I'll get on the sick for life again, because my problems affect my day-to-day living.'*

Another respondent also talked of the financial difficulties of transition, but in his case it related to the transition from IB to JSA and then to work. The respondent described how, once he moved off benefits, he struggled to achieve the income he had previously received, to the extent that it began to affect his health. Although the respondent managed to avoid going back on to benefits, he advocated extra support for people making such changes to their lives.

### 3.2.2 Barriers to benefit uptake

This section considers the various barriers that the respondents faced when attempting to claim benefit. It explores how lack of knowledge and the difficulty in obtaining advice can make claiming benefit very daunting and difficult. It then goes on to consider elements of the application process and Jobcentre Plus infrastructure that pose particular barriers to PDUs. Lastly it explores the stigma and discrimination that some respondents reported having to face from benefit officials during their application.

#### *Knowledge of the benefit system and obtaining advice*

Most interviewees seemed to have a good level of understanding of the benefit system, yet there were some whose understanding was very limited.

*'I don't know what to claim at the Jobcentre...[I'm not signing on at all] 'cos I'm on a course. I thought you got disqualified.'*

*'I know you can work 16 hours and you're okay to do so and still get benefits, but I do know that...I think that's right. It's not right that you can work for 16 hours and they won't chop your benefit, they will chop your benefit, from what I've heard if your money is substantial enough. That 16 hour thing, I'm not quite sure where I stand.'*

Perhaps underlining some respondents' lack of knowledge regarding benefits was the apparent under-provision and inaccessibility of advice services in some of the areas in which interviews were conducted. One female interviewee described a past experience where she had been recommended to attend a Citizens Advice Bureau (CAB), for advice regarding an application for DLA. She described how she was deterred from attending any appointments because of the distance to the nearest CAB and the complicated care of her young child:

*'...and they say that "oh, if you need help, there's the Citizen's Advice Bureau", but try and find a CAB around here – it's nigh on impossible. I think at the time, the nearest one was in xxxx, and I had got a child who was too ill to be taken out, so I had to let it go...'*

Another respondent who was asked about the availability of CAB in their local area also said that distance to the nearest branch was a problem:

*'They're never open. You used to be able to just walk in but you have to ring for appointments for that now. And that's in xxxx so again you have to walk to xxxx or borrow money or whatever [to travel].'*

#### *Difficulties with benefit system processes and infrastructure*

Respondents also discussed barriers to benefit uptake in terms of dealing with the processes and infrastructure used to administer benefits. Such barriers included filling-in application forms, attending appointments and what interviewees perceived as an insensitive environment.

### Filling in application forms

Some interviewees mentioned difficulties filling in benefit application forms and requiring extra help:

*'I say "I struggle with the forms. I never seem to fill them out right. Can you help me with the forms?" Usually somebody here will help me. They fob me off,... One time you could just walk in and say "Is anybody busy, can you help me out with this form?".'*

*'For the last few years I found it a lot easier, when I first got my flat in 1992 it was very difficult. You know because you didn't know what benefit you were going to be on and you had all these forms to fill out. A person from my background trying to fill a form out is very difficult, on your own, you don't understand, you just don't understand them.'*

In particular, a number of respondents described the problems they faced filling in the application form for DLA. Respondents outlined how they struggled with the form because of its length and therefore the degree of effort required to complete it. Furthermore, respondents who were eventually awarded DLA reported that they attempted to fill out the form on at least one other occasion, prior to benefit approval. One interviewee explained that a previous attempt at filling in this application on her own caused her so much stress that she failed to finish it.

*'...The forms are extremely lengthy and, kind of, really specific. Like, they talk about hours in a day, and with what I've got wrong with me, it becomes very...stressful...and they refused, to begin with, and I had to appeal and then they agreed. So it was a very difficult process, probably why I'd taken so long to actually claim it. I know that I tried filling out a form a few years ago and it was too much but where I was given housing I had this key worker to sit me down and do it with me, but it was very difficult, applying for Disability Living Allowance, it's not an easy benefit to get, if you can't do the forms for. If you've got problems like I have.'*

### Attending appointments

A number of respondents reported problems with attending appointments in relation to their benefit claims. Some respondents, from a particular area, said how they had missed several medical examinations because of problems with transport. Asked why she had missed two medicals, one interviewee, who subsequently lost her claim to IB, responded:

*'Because they were in town and they didn't have any transport around there. I just couldn't get there.'*

Another interviewee's reason for not attending medical examinations was that he couldn't afford the cost of travelling to appointments because of ongoing drug use.

*'I've missed a few. People can't get through. Especially when you're on benefit and you've got drugs to buy. So, I had my benefit stopped because I couldn't get through there. But I phoned up the day before and said I want a crisis loan, and they wouldn't give us it, even though I said it was for bus fare to get through.'*

Further respondents talked of appointments with benefits staff clashing with treatment requirements. One participant described his concerns regarding competing obligations to pick up his substitute prescription of methadone and regularly attend Jobcentre Plus. The participant discussed an occasion where staff stopped him from signing on at the jobcentre, because he was late attending.

*'...sometimes, it's a bit of a mess about because, it can clash, when you go to sign on for your benefits, it's proper strict. If you go in and you're a minute late, you don't get your money. Having to sign on, that's a nightmare that. ...when I'm going to pick my methadone up, I'll say "I'm supposed to come here and sign on..." two weeks ago, I turned up two minutes late and they wouldn't let me sign for my money. They wouldn't let me sign. But I'm one of these people that go to the Jobcentre two or three times a week looking for a job.'*

Another interviewee described a situation where he missed a treatment appointment to attend a meeting with a Progress to Work adviser, despite his claim to IB having recently been reinstated.

*'I was pulled in for a Progress to Work meeting and she said, "it says on my screen that you're looking to do some voluntary work and maybe some part-time work". And I said, "well, that was a long time ago. That was last year, last summer. Since then, I've had a relapse, and a nasty one, because it don't get any better, they just get worse". So I said, "I've just come out of a detox unit and you've actually got me out of treatment today to come to this interview". And they know that I'm signed off until 2013 as a result of winning my appeal.'*

## **Infrastructure**

Many respondents also complained about the environment in which Jobcentre Plus staff conduct interviews and the way in which benefit claims are administered. A particular concern was the use of telephone helplines instead of face-to-face meetings with benefit officials. Some respondents, none of whom receive JSA, described how they have had little opportunity to speak to a member of staff within Jobcentre Plus.

*'...I don't really speak to them that much. As soon as I go in there, they tell you to use the phone, so you don't really see them face to face, if they do speak to you.'*

*'You can't go to see them, it's all over the phone. You can't do anything, it's a waste of time, you're on the phone, it's a waste of time. There's no-one there to talk to you...'*



*'I don't want to talk to people over the phone. You want someone sat there face-to-face with you – you feel more comfortable.'*

Some interviewees in this group contrasted this experience with that of earlier contact with the benefit system, which they viewed more positively.

*'...everything's been rerouted through the phones and there's no more personal interaction. It used to be easy, years ago, when I was up in xxxx, used to go in there, you'd sit down and you'd talk to somebody and that person'd be on the case for you and it was done, pretty much on the spot ...but now it's all done over the phone and the post and it can be quite frustrating or laborious, but you get there in the end.'*

*'Basically, I can walk in and say, "well, I've got this piece of paper here, I'm not too sure about this". Now, what they should do, they should help you but nine times out of ten, what they say is – "there's a phone over there. Press button B with enquiries on it, then press option 4 and ask them". And for me,...that's just saying, "we haven't got time to deal with you, so you just sit on the phone for 20 minutes and wait for them to thingy", when they could answer your question for you. ...when I was younger and on the dole, it was more easier. There was more help. There was more staff in there, you could get more things done.'*

Another potential obstacle to applying for benefits, which arose in a couple of interviews, was a lack of privacy in interviews with officials at Jobcentre Plus. One interviewee complained that conducting interviews in an open-plan office did not provide the right environment for discussing sensitive issues such as drug use.

*'I don't think they should do it in an open ring where there's a lot of other desks and a lot of other people. I think they should be taken into another room and talk about their situation there in a one-to-one basis, not where the whole building can hear you. I mean, you've got desk, by desk, by desk and you've got the next person, who's on Income Support and an elderly lady who just turns her nose up at you because you're an addict, you know, this is what it comes to and you walk away feeling uneasy.'*

The interviewee went on to suggest that having a private interview space may encourage drug users to be more open.

*'If it was a one-to-one situation where the jobcentre could take you into a room, have a chat with you, I mean, there's a lot of people who can lie about their situation, but if people were more honest about their situation...then it would make life easier for the jobcentre, so I honestly think that a one-to-one session with them to acknowledge your situation, even go away and maybe talk to someone out of the team.'*

### *Relationship with Jobcentre Plus staff*

The relationship between benefit claimants and Jobcentre Plus staff was highlighted as a barrier to benefit uptake due to two issues raised by respondents. These included a perception of stigma and discrimination in the attitudes of benefit officials; and also a belief that certain standards of behaviour, on the part of clients, can elicit a better service.

Some respondents perceived stigma because of their ongoing benefit claims whilst others believed it was due to their drug use.

*'They say they're helpful, but they're not. I think they just stick their noses up at you. To them, I think I'm just another smackhead...It's as if they can't be a\*\*ed.'*

*...just their attitude alone was – I just felt I was nobody, yeah. they just made me feel very uneasy within myself, and like I was scum...In the past, I don't think anyone's listened from the jobcentre – "yeah, another income supporter", you know what I mean? "Not worth it, doesn't want to go out and get a job". Not all of us are like that.'*

*'They are doing their job and I understand that they have had to work to get to where they are, but I really don't like it when they stick their nose up at unemployed people.'*

One respondent, who had recently applied for a crisis loan, described how he felt staff at Jobcentre Plus do not believe him when he talks about his circumstances.

*'Like, if I try to get money for a course or something they'll think that I'm just trying to get money for drugs or alcohol. So if I'm in a really bad situation where I've got nothing, I'm on the streets and I've got nothing, and I'm signing on but I've got no clothes, nothing, most of the time they just think "oh he's lying, he wants money for drugs".'*

A number of respondents interviewed in one particular study site expressed how they felt they had no problems dealing with Jobcentre Plus staff because they were able to behave in a certain way. The respondents felt that being able to communicate with workers appropriately and effectively made securing help easier. Having disclosed the fact that jobcentre workers were aware of his drug use, one interviewee described how he was prepared to overcome any negative attitudes.

*'I think quite often,...people have preconceived ideas about you. And quite often, drug addicts and alcoholics live up to them ones. However, I tried my best not to. And as a result of that, I think in some cases they might have been mildly surprised that actually I had manners and could speak English properly...I wasn't a typical user. And so, therefore, I found that I didn't feel as if I was being mistreated, let's put it that way. Now I don't know what they were thinking, who knows, but I didn't get the feeling that I was being particularly mistreated and it was purely because I think I was able to communicate with them okay.'*

Another interviewee described how he had learned the importance of communication after initial problems.

*'It's tough when your mental state is shot to bits like that and trying to – you get very frustrated, because all you're thinking about is me, me, me and it takes a long time for you to understand yourself and then be able to work with the agency and say, "well, actually, if I'm polite to these people, I'll get a response" and there are rules and regulations that you have to go through to get some support.'*

In summary, interview respondents highlighted the complexity of accessing benefits and barriers to benefit uptake. Although some reported few or no difficulties understanding the benefit system, the accounts of others suggested significant difficulties. According to the interviewees, this is a situation made worse by the poor availability of benefit advice services. Respondents also faced difficulties with the process of applying for benefits in relation to lengthy application forms; attending appointments outside their home-town and having to make enquiries using inappropriate facilities. Respondents also felt discouraged by the perception that officials provided them with a poorer service because of their drug use. Some interviewees held the view that workers looked more favourably on people who could meet their expectations.

### **3.2.3 Looking for employment through Jobcentre Plus**

This section discusses respondents' experiences of using Jobcentre Plus to help in their search for employment.

#### *Quality and relevance of available jobs*

Some respondents encountered problems in matching their employment expectations to the types of jobs promoted by Jobcentre Plus. One interviewee said that, although he has found work he enjoyed through Jobcentre Plus in the past, due to his background in joinery he generally relied on obtaining work through word of mouth.

*'I've never really had a job through them [Jobcentre Plus] the work I'm in, it's like I'll see my mates for jobs things like that now, just word of mouth, if I'm talking to people where they're working, you know I've never, I think I've had a job once through the jobcentre, don't get me wrong it was a f\*\*\*ing brilliant job, I think it was the best job I've ever had.'*

Another interviewee described how, in her experience, many people recovering from drug use find work through volunteering, with no input from the jobcentre.

*'From what I hear, a lot of people in recovery get voluntary work first and, there's a natural progression into work from there, so the jobcentre's not even involved. It seems more like a gateway thing that they do through voluntary work.'*

Other interviewees complained about the quality of jobs on offer within Jobcentre Plus, implying that such jobs offer few prospects.

*'I mean what I find is for me looking for work that the papers are far better, and there's one or two papers particularly, ...but the internet, the internet really tends to be the place that I would look up for work, em, if you're looking for work in McDonalds yeah go and look in a jobcentre, but if you're looking for work in specific fields then jobcentre's a waste of time. I had, it's about two years since I visited a jobcentre 'cos when I did go there, it's a waste of time.'*

*'When you've got a service user who hasn't worked all his life, and you are offering him a job in a really poor factory or something like that, it's not always what they want, you know what I mean?'*

### *Insensitivity to specific circumstances*

Some respondents expressed negative views regarding Jobcentre Plus staff's understanding of their circumstances in relation to finding employment. A male respondent talked of his concerns in relation to being advised by Jobcentre Plus staff not to disclose his prescription for methadone when applying for a job. The respondent worried about the possibility of accidents if he was required to use machinery, and the consequences of withholding information in such a situation.

*'...you could look for work, but they just don't understand. They kept on saying to me "don't declare you're on medication" and I kept on saying to them, "what happens if I'm liable for it, though", know what I mean? And they still didn't understand.'*

In contrast, a female interviewee described being deterred from applying for a job because of her methadone prescription, which suggests a certain degree of negativity regarding the capability of PDUs.

*'Sometimes I feel that they look at you a bit different, I think some people do, but then you're a bit more aware if you're applying for a job and they can say "well you're on the methadone, I don't think you'll get it because you're on methadone".'*

A male interviewee said how he felt Jobcentre Plus staff didn't understand the difficulties drug users face getting back into employment.

*'Well, they just, I don't know, they don't give you the help that you need and all that. They just shove a bit of paper at you and say, "phone them for an interview". But with us being on drugs for years and years, we don't know how to go in there and have an interview. You know what I mean? I just don't – I don't know how to go – they say go on the computer and look for a job, we don't know what to do. We've never done it before.'*

### *Room for improvement*

Several respondents felt that Jobcentre Plus could do more to help them find employment. One interviewee felt that jobcentre staff could work more closely with clients, not only encouraging them to apply for jobs but also ensuring that they follow up opportunities.

*'They ask me if I've been looking, where I've been sending forms to, looking at the job pages and they look on the system themselves to see if there's any jobs for me. And if there is they'll give me the information and then they'll leave it up to me to send my CV or ring them up. I suppose they probably could do more because they might give you information on someone and that person might think "Nah, I'll leave it" and then the jobcentre's not going to know, are they? I think the jobcentre, if they find a job for you, should contact them there and then with you.'*

The same respondent expressed his frustration at not being able to participate in certain training courses until he had received JSA for a set number of months.

*'They could try and put you on more training courses to try and get you back to work. There are certain courses on the New Deal and Pertemps, but Pertemps you can't go to until you've been on the Jobseeker's for 18 months and I thought that was a bit much because I would have gone to them straight away.'*

Another interviewee also described how he would appreciate a more proactive approach to his employment prospects. The interviewee, who suffered from mental health problems, was keen to get back into work to keep his mind occupied. Asked if he receives enough support from Jobcentre Plus, the participant reported mixed views.

*'Yes and no, because when I see my Pathways adviser, she offers me all the support I need, but if I don't take it there and then, I have to wait until I see her again before I can access it. So, it could be a month, two months, before I see her again.'*

Another respondent suggested that Jobcentre Plus could work alongside drug and alcohol support agencies to help people get back into work gradually.

*'Like if the jobcentre people worked alongside centres like this, and you worked along with people and you could say, "okay, they're going to gradually get you back into work" but you've got to show some incentive that you're working on yourself, you're developing and as you go along and you go to college and then, things like, getting an education.'*

Furthermore, another male interviewee was asked if Jobcentre Plus staff had helped him to find employment. He said that he received no help.

*'They don't – they don't serve you, like. With it being Jobseeker's, they don't say to you like, "are you available for work and all that?" "Have you been looking in the papers?" Which I have, you know, a good few times.'*

### 3.3 Employment and future aspirations

#### **Summary**

##### **Barriers to employment**

Drug users face a variety of obstacles with regard to looking for employment, of which most are deeply entrenched. These include poor self-confidence and mental health problems, physical health problems, a lack of education, training and skills, ongoing drug use, receiving treatment whilst working and stigmatisation by employers, amongst other barriers. Many of the obstacles highlighted, such as a lack of education and training and ongoing drug use, have the scope to be improved by the individuals concerned providing they have the support and motivation to devote time and effort to them. However, other barriers may prove harder to overcome and require broader societal change. The reported reluctance on the part of employers to take on individuals with a history of drug misuse, or with criminal convictions, is an obstacle that is rooted in social attitudes and therefore much more difficult to alter.

##### **Informal economy**

Interview respondents' accounts provide compelling evidence of the link between drug misuse and crime, as established in the literature review and by other studies that have examined the experiences of PDUs. Respondents commonly admitted to involvement in shoplifting, burglary, drug-dealing and fraud as a means of obtaining money for drugs. In some instances respondents who had been involved in drug-dealing spoke of being motivated to sell drugs because they had easy access to them. As a result of such crimes, many interviewees had spent time in prison, with some having spent most of their adult life moving in and out of prison. Involvement in the informal economy was common amongst respondents, with most admitting having done cash-in-hand work. This, as well as some interviewees' involvement in prostitution, further highlights the barriers that drug users face in finding legitimate employment.

##### **Future aspirations**

Almost all interviewees viewed becoming drug-free as a higher priority than coming off benefits and getting a job. For many, this involved coming off a methadone prescription. Conversely, however, some wanted to start taking methadone precisely so they would be able move back into employment, illustrating just how personal ideas about what constitutes recovery are. Many interviewees worried that they would not be able to cope with the pressures and stress involved in working life and feared a relapse as a result of these. Interviewees generally saw voluntary work, often with drug treatment services, as a first step towards paid employment. This represents a way for them to test out their ability to work, and also to give something back to their community and help support others in a similar position.

### 3.3.1 Barriers to employment

As we outlined previously, only a few respondents in our sample were in paid employment at the time of the study. Interviewees identified a number of barriers to finding employment. These included issues around confidence and mental health; physical health problems; previous criminal convictions; the stigma of being a drug user; a lack of education and skills; problems applying for jobs; continuing treatment and current drug use.

#### *Poor self-confidence and mental health problems*

A fairly common theme in discussions regarding barriers to employment was the issue of poor self-confidence, in many cases reflecting mental health problems such as depression and anxiety. Respondents discussed feeling incapable of meeting demands in relation to work and job-hunting, as well as in relation to other aspects of their everyday lives.

*'If I went for a job interview it would make me nervous. Sometimes when I have something to do with that, I've not went because I'm thinking to myself... "they'll be calling me this, they'll be calling me that".'*

*'I have the depression. I can't function and I'm on the drugs. But I think it's the heroin, that's all. I've lost all confidence in myself.'*

A related issue to that of poor self-esteem expressed by respondents was a fear of relapse if they returned to work before they felt ready.

*'I mean I get a bit depressed and that from time to time, you know, and I feel as if I'm not ready for work, yet, I've got still a lot of things on my plate to deal with... I don't get out much... still think about using a lot... and I don't feel ready yet... I've got that much to lose.'*

*'I'm not ready now... I'd be setting myself up for a fall... I relapsed recently... I suppose it's a case of when things get bad... you go back to what you know, a safety blanket, I suppose.'*

In addition to respondents whose mental health problems contributed to poor self-confidence, other interviewees highlighted mental health problems as an obstacle in themselves.

*'I want to work, but if I try to work, I just – I just schiz-out and paranoid out and walk out of wherever I am.'*

*'If you're suffering from a mental illness, your mind will take you anywhere, you know what I mean. I've got like, a personality disorder, that's what they put it down as, a personality disorder. One day I can be, like, normal, and another day I'm very – revealing myself and depressed and feared up.'*

### *Physical health problems*

A common theme amongst interviewees was the physical health problems that may prevent them from finding employment. In particular, a female respondent spoke of her diagnosis with Multiple Sclerosis, whilst some respondents discussed ongoing work-related injuries.

*'I was lifting some heavy objects and I didn't lift them properly and I hurt my back off that. I've got a metal plate in my shoulder, so I can't lift my arm right up over my head.'*

Additionally, other respondents discussed having hepatitis C, contracted as a result of injecting drugs. One interviewee, who was soon to begin treatment for this condition, was hopeful he would return to work once this treatment was complete. Another interviewee, who also had additional health problems, felt he had to prioritise working over gaining treatment.

*'I got cirrhosis of the liver and hepatitis C through taking drugs. I've got to tend those things and things like that but because I have to work I put them, you know that's the last thing on my list when really it should be the first thing on my list.'*

### *Criminal record*

In interviews, those respondents with criminal records were mindful of the possible negativity they may encounter from employers.

*'...maybe you could pass one occasion or whatever, one mistake but you can't pass 11 times. Eleven mistakes sent me to prison. An employer sees that on a piece of paper he'll be like "he's been to prison, that's no good, I don't want to employ him".'*

*'I worked for Royal Mail...in the sorting office...for about three years...they started doing checks on people and I had a criminal record so I had to go...I couldn't take the embarrassment.'*

However, some interviewees admitted, they too would find it difficult to look beyond a person's criminal record in certain circumstances.

*'I'd like to work with children but you know, realistically, I think if I was looking for someone to look after children, I wouldn't want them to have a criminal record at all, let alone selling drugs.'*

### *Stigma*

Some respondents also voiced their concerns in relation to obtaining employment, with regard to stigma. As drug users, interviewees outlined the damaging stereotypical perceptions that they've encountered. One respondent suggested that employers' lack of trust in drug users makes employment unstable for this group.



*'It's in and out, it's in and out cause you're a junkie nobody trusts a junkie.'*

Moreover, another respondent talked of the extra effort required to overcome negative attitudes held by employers.

*'Being on the gear, it's different. It's getting that one person to give me a chance. As soon as someone gives me a chance I'll be able to prove myself.'*

Further illustrating the impact of stigma, a male respondent with a history of alcohol abuse described the problems he faced when he attempted to return to work after treatment. The interviewee talked about the response of two recruitment agencies:

*'It was all "your CV looks great, we're going to put you forward to so-and-so organisations", a bit all of a sudden; and "what have you been doing since April 2005, ...just to give the client the icing on the cake?" Well, you know, you explain as quietly as possible as you can, that change of family circumstances – I dressed it up to the extent that it was a marriage breakdown. It was a marriage breakdown because of the alcohol abuse. But I made it up as a marriage breakdown, problems re-organising my life, you know, drinking too much, threw that in, and hey, the phones closed down.'*

#### *Lack of education, skills and training*

Some respondents also felt their employment prospects were restricted by having had a poor education and the fact that they had few skills and qualifications.

*'But I think the main thing that'll stop me getting work is lack of education.'*

One respondent described the disappointment he faces when he applies for a job and finds he doesn't have the qualifications required.

*'I get called in because I have to tell them about what I've been doing looking for a job and that, then I sign the piece of paper and go. I look at the computers and that. You look at a job and you think "yeah, I'll apply for that" and then you go to the job and then they say you need all these qualifications, you need to do this and that. That's a bit of a bummer.'*

Another respondent felt qualifications could actually provide him with a job he would enjoy instead of one with few prospects.

*'I don't think I've got enough qualifications, I don't want to be in a dead end job, I want to be in something that I enjoy.'*

As a result of such restrictions, many interviewees felt they would have to return to education or training to obtain the knowledge and skills required by employers.

*'Probably I haven't got enough training for certain jobs. I've just done, like, factory jobs and I'm wanting to do more.'*

*'I'm seeking education, and I am looking for ways to tiptoe into it. Lack of education and lack of experience.'*

### *Applying for jobs*

Interviewees reported difficulties with applying for jobs in two respects. In the first instance, some were daunted by the prospect of putting together a CV and attending interviews.

*'I'm not applying for jobs because I don't even have a CV. I need help with a CV.'*

*'And it's just doing it, isn't it, because I've never been to work before. I've never been to an interview. I've never even been to an interview.'*

Secondly, other respondents discussed the issue of trying to account for long gaps in their CV and a lack of references.

*'It doesn't look good...if I went for a job and they say, "right how have you not been working for the f\*\*\*ing last seven years".'*

*'I find it difficult to lie and pad out those three, two and a half, it's now coming on three and a half years, four. And to some extent I've stopped, I've given up because – particularly with what's been going on in the press recently, but yes, I felt that – I was always asked; God, xxxx, your paperwork looks brilliant, up until – April 2005. It doesn't matter that from April 2005 back, 30 years, it looks brilliant. It's a blank page, 2006 – 2007.'*

In particular, a female interviewee who stole from her previous employer outlined the difficulties she faced regarding references.

*'At my last work they said they wouldn't ever give me a reference for another job. That's the only thing, you need to have references, don't you?'*

### *Receiving treatment whilst working*

Some interviewees also highlighted the difficulty of holding down a job whilst receiving treatment for substance abuse. They wondered how employers would feel about employees attending treatment sessions, or picking up substitute prescriptions from a pharmacy, when they would otherwise be expected to be working.

*'...after I've done the detox and I'm ready to go back to work, I'm not sure what sort of requirements they want of me and whether it's going to be feasible to be able to go out to work if they want me to come in x amount of time a week. I don't really want to have to explain that to an employer, because obviously they're going to frown on it.'*

*'If you get the job and then picking up your methadone, your scripts, coming here, it could clash with the time when you're working, so that could mess it up.'*

Furthermore, one respondent described how he had lost jobs in the past because of problems picking up his substitute prescription.

*'I've lost a couple of jobs because of my script 'cos I have to pick my script up every day. Because the chemist isn't there, or I have to wait, or one thing or another I can't get to work in time because the chemist isn't open early enough.'*

Other respondents worried about the side effects of medication having an impact upon their ability to work properly.

*'The side-effects of all my medication and the health problems that I do have, I find that they inhibit me and if I was to go back to work I'd have to find a very sympathetic employer.'*

*'I'm on sleeping tablets which mostly make you drowsy the next day. And I'm on diazepam because I'm a recovering alcoholic as well.'*

### *Ongoing drug use*

Similar to the issue of receiving medication, and the impact this can have on an individual's ability to hold down a job, is that of ongoing drug use whilst in employment. Interviewees described how they had worked or were working while using, even if they were also on medication. They described how difficult it is to maintain a job when also struggling with an addiction. One interviewee described an experience where his drug use put him at risk of injury whilst working on a building site.

*'I've always tried to do it after work. You get into a pattern. Some people can't go 24 hours completely. Physically, it should last you, but mentally, it's an issue if you want it...I did it a couple of times at work and found out to my painful experience that it's not that clever when you're trying to walk along a load of batons and, if your vision's impaired at all, you're sticking your foot through the holes and not where you should be treading.'*

Another respondent illustrated how drug use can also threaten employment by undermining a person's ability to engage in typical social situations and remain in control of their emotions and behaviour.

*'You get angry and stuff for no reason...so it's quite hard to co-operate with people...If you're a heroin addict, you just have these days where you can't be bothered, you just don't want to move, you don't want to see anyone and you don't want to talk to anyone.'*

### 3.3.2 Informal economy

This section summarises our findings regarding interviewees' experiences of working cash-in-hand, and being involved in prostitution and criminal activities. Also briefly outlined are interviewees' experiences of prison.

The majority of interviewees admitted to working for cash-in-hand payment at some point during their working lives, and some also admitted simultaneously claiming benefits. Most of the jobs undertaken could be described as unskilled.

*'Labouring, a lot of the time. There were some building sites, working in pubs as well. I was working behind bars when I was 16 years old.'*

*'I've done the odd cleaning job, and I worked in a hotel for a while, on the reception, but they were cash in hand so, yes, that's why it's difficult to come and do this stuff, because I suppose a lot of people like me, that will have, in the past, if they're really honest, done both.'*

Many of the interviewees admitted that they had financed their drug use by shoplifting, theft and/or selling stolen goods. The most commonly mentioned criminal activities were shoplifting and burglary

*'I've done loads of shoplifting...to feed my habit.'*

*'I used to shoplift a lot...yeah, for drugs.'*

A strong theme amongst respondents was that of being involved in selling drugs (although it seemed that many of these individuals used as much as they sold).

*'Been in prison for dealing. Yes. The dealing was always a part of it. I was always dealing, even when I was at my worst, I was dealing, 'cos it helped you get along, helped you get the next batch. I was one of those users who always dealt. I was a user who always bought in quantity so I've done it, used and sell it to fund my own habit.'*

Some interviewees reported serving time in prison, mainly for theft, burglary and drug dealing. Many of the sentences could be described as short-term, and a lot of the interviewees had been in prison on multiple occasions.

*'I haven't done a long time in prison...I only mean weeks, three weeks here and there. I've done a lot of short-term sentences. The longest I've done is six months.'*

However, some of the interviewees had committed more serious offences, and one had been jailed for attempted murder and served a three and a half year sentence for the offence.

*'I've done 19 years of my life in prison, 19 years in total out of my life in prison.'*

*'All sorts of stuff. GBH, burglaries, resisting arrest with a firearm, assault, dangerous driving, the attempted murder of police officers in cars, all sorts of stuff.'*

Some interviewees (both male and female) had been involved in prostitution. One woman described continuing to work as a prostitute, despite her drug use having stabilised.

*'I still do it now, two nights a week. That's just working the street. At one time it was to feed a habit which I no longer have. Now, because I'm on a lower rate money-wise, it's just basically a back-up.'*

Another woman described being forced into prostitution, with drug use being a response to this.

*'I was raped and kidnapped and put on the street by a group of yardies and that's when I got introduced to cocaine as a painkiller.'*

Some male respondents said that they had acted as minders for prostitutes. For this work, each man said that they were paid in drugs.

*'I used to hang about with working lasses and all I had to do was keep an eye out for them, things like that and they would generally, every night, get crack, without a doubt.'*

Several respondents admitted involvement in fraud, including fraudulent benefit claims:

*'I've hurt a lot of people. I've taken liberties with benefits and things like that in the past where I've been on the dole, when I was on the canal, you know, working.'*

*'I've been in jail a couple of times. One because what I'd done was 18 months for conspiracy to supply drugs. Also, I've been done for theft and I've been done for fraud. That's basically it.'*

### **3.3.3 Future aspirations**

For the vast majority of those interviewed, becoming and remaining drug-free was their primary aspiration. Indeed, for some interviewees it was their only aspiration at the time of the research.

*'That's what I'm aiming for, yeah, to be drug-free and off it all.'*

Many then went on to state that becoming drug-free was far more important a goal to them than getting a job.

*'Probably getting off drugs. That comes first before getting a job.'*

*'The drugs have priority over my life. I mean, drugs, my addiction was [my] priority. Even my liberty wasn't a priority, my health wasn't a priority, [it was] the drugs.'*

*'As far as I'm concerned, there isn't any major rush to get back to work, as long as I'm doing something constructive, daily, it doesn't matter if I'm in paid employment or not. As long as I'm off the gear, off the drink.'*

One respondent went further and described a direct link between becoming abstinent from drugs and entering the job market.

*'Getting off drugs is the number one issue, isn't it? If you can get off drugs, you can get a job.'*

When asked about their aspirations for employment, many of those interviewed wanted to start with voluntary work, and most of those people suggested that they wanted to work in the drugs or alcohol field.

*'I want to work, I want to be able to go into prisons and meet guys who've got the same problems, help to motivate them and challenge themselves and work their way out of the system, out of drug dependency.'*

Some other interviewees wanted to work for more general support services, or those focused towards other socially excluded groups.

*'I'd like to be a social worker, so going down that road, really, access to a uni course...'*

*'I'm trying to improve my chances of getting work in the support field, working with people...I wouldn't mind working with the visually impaired.'*

*'I'm seeing a counsellor, you know, and I'm doing sign language teaching so I'll be able to coach people.'*

Most of those interviewed expressed an interest in working in the drugs field; however, some were envisaging that as being voluntary, unpaid work. It is not clear whether they were thinking that they would remain on benefits while doing such voluntary work.

*'Well I hope to eventually work in the drugs field, but that doesn't have to be paid, I'd do that voluntarily.'*

It should be noted, however, that the recruitment for the study was organised through treatment services. Therefore, those interviewed were engaged with such services and as a result the aspirations expressed by this group may not be representative of all drug users, particularly those who are either not in treatment or who have negative views of drug treatment or support services. The respondents are more likely to be interested in 'user involvement' or representing service users, and therefore in giving something back to their communities, than PDUs in general.

One person was quite vocal about their future aspirations in terms of moving off benefits and into work.

*'I don't want to put my hand out to the...government, I don't want to live on benefits, I want to be able to pay my rent. I want to be able to do this and go to work and earn my own money. It's time I put back into society.'*

Another respondent expressed a similar sentiment.

*'...whether I'm fit enough to go to work or not, I don't care, because I've been claiming benefits on and off for eighteen years I want to be out there, I want to work.'*

Some interviewees voiced aspirations that would be shared by the majority of people, regardless of their personal circumstances.

*'I don't know, hopefully a nice job and a nice flat, settle down. That's it, really.'*

*'To be able to move from that to somebody who's now quite stable, going to college, doing a little bit of voluntary work when she can, being a good mum to my kids, I think I'm better off on the script and it's only the script that's managed that.'*

However, some respondents were quite clear that, at this stage in their recovery from drug use, they just could not think about their aspirations or even begin to think about the future.

*'A year from now? I haven't thought that deeply about it, you know. I'm still in the early stages.'*

There was a group of interviewees who came across as quite negative in their aspirations or found it difficult to express an aspiration. A lot of this was related to their past drug use, with many describing their situation as being off drugs, but still experiencing lots of problems relating to their previous use of drugs, or indeed the factors which drove them towards drug use in the first place.

*'So physically I'm able to work and stuff but mentally, I'm still a bit withdrawn, so it makes it difficult.'*

*'I wish there were time[s] when I didn't feel so horribly miserable, I'm getting worse and worse actually. I've always been prone to being a bit melancholy, but it seems to get worse sometimes and I don't like that.'*

And while some expressed an aspiration to enter the job market and work, they also discussed their genuine concerns about the structures and stresses attached to entering employment for someone who has been out of the job market. There was a fear that such issues would set them back and probably make them relapse into drug-taking.

*'I could go to work tomorrow, but I'd probably end up relapsing and doing something really stupid at the end of three months, when my intolerance got – whatever.'*

Some interviewees expanded on this to describe it almost as a revolving door, where they would find a job, remain stable and abstinent for a few months, then, almost fatalistically, end up back on drugs.

*'I rushed back into it again too quickly, I felt pressured into going back to work and I really wasn't ready mentally, I just wasn't ready and I used.'*

Interestingly, some even noted that the positive benefit of bringing in an income, or at least a level of income higher than that attained by being on benefits, had led to them receding back into drug use.

*'As soon as the money started coming in again, the recreational use started up again. So, whenever there was money available, I'd use it [for drugs].'*

Another respondent also described a situation where part-time work may have its own issues.

*'[I'd need] Full-time [work] really. If I went part-time I'd end up going drinking and I don't want to do that, because that defeats everything I've done.'*

As with the quote above, many respondents suggest that the pressure to get back into work could lead to unrealistic expectations or timescales.

*'They're trying to push you back into work. But I'm on a methadone script, it's not going to work.'*

*'It's just going to take time...It doesn't happen overnight.'*

A number of respondents who were currently on methadone suggested that this dependence on a substitute drug affected their aspirations. Most suggested that their main hope was to come off methadone and be totally drug-free, and expressed this as an important step to becoming 'normal'.

*'I want to be doing work, you know, that sort of thing, just a normal life...I just get sick of having to be on meth...I just want to get off it really and be normal again.'*

While some described wanting to come off methadone and get a job as almost a single aspiration, quite a few of those on methadone clearly stated that getting a job was more important than coming off a substitute prescription and becoming totally drug-free.

*'I'd like to get a job; really, I would...If I could get a job and just cut down the meth, yeah.'*



Some respondents went further to suggest that the ability to gain employment is one of the reasons they are either on methadone or would like to be on a methadone prescription.

*'This is why I want to get on the methadone, so I can actually take the methadone and then be all right and go back to work...it's getting quite boring just sitting in the house staring at four walls. It's just getting me down at the minute...I'm used to working.'*

## 4 Professional interview findings

In interviews with ten professionals in the case study sites, a range of themes relating to drug use, benefits, treatment and employment were discussed. Some interviewees had more knowledge and experience of the benefit system than others and were able to comment in detail on this issue, while others focused more on other forms of support available to problem drug users (PDUs) in their area. All interviewees were employed in a role that involved regular, in most cases daily, contact with adults with substance misuse problems, in particular PDUs. Their accounts of the challenges faced by this group and the complex nature of the types of support needed were detailed and add an alternative perspective to those provided by drug users in the previous chapter. The main themes emerging from the interviews with professionals, around which this chapter is structured, were:

- the characteristics of PDUs;
- the benefit system;
- treatment;
- employment;
- partnership working.

## **Summary**

### **Characteristics of PDUs**

Professionals described PDUs in their areas as a marginalised group who experienced stigma and had complex needs, including mental and physical health, employment, housing and family problems. They felt that drug use both exacerbated pre-existing problems and led to new ones. Views were divided about whether PDUs are generally willing to disclose details of their drug use to professionals, however, there was consensus about the fact that they are at strong risk of stigma and discrimination.

### **The benefit system**

Views were mixed about the role of the benefit system in drug users' lives. Some professionals felt that the system provided a perverse incentive for PDUs to appear as disabled as possible in order to gain access to a higher level of benefit, whilst others emphasised the importance of benefits as a safety net that enables drug users to survive. As such, many described benefits as a central component of recovery from drug use. The most common benefits for the interviewees' clients to be receiving were Income Support (IS) and Incapacity Benefit (IB), as well as Jobseeker's Allowance (JSA). Various barriers to claiming benefits were identified, some of which were the same as those identified by the PDUs themselves earlier in the report, such as problems with filling out forms and attending appointments. Others were similar but expressed in a different way, such as the mismatch between the behaviour of their clients and Jobcentre Plus staff's expectations of them that the professionals described. They emphasised the importance of advocacy by, and support from, facilitators in helping drug users to negotiate the benefit system.

### **Treatment**

Treatment services were available to PDUs in all of the case study areas, however, interviewees acknowledged that a drug user's decision to enter treatment is a very personal one which is hard for them to influence. They also identified waiting times as a problem for those who decide they do want treatment. Paths to recovery were described as long and complex, with most clients going through treatment multiple times. They felt that whilst returning to work was a more long-term aim for most clients, training and voluntary work is a good stepping stone to employment for those who are ready for it.

(continued)

### Employment

The vast majority of drug users that the professionals encountered were unemployed. Where they were employed legitimately they tended to be in low paid and short-term jobs. The professionals emphasised the positive impact that employment can have on PDUs' lives, however, they acknowledged that the transition from benefits to employment is a challenging one for this group and mentioned mental health issues, medication, employer attitudes and time out of the labour market as some of the barriers that they face. The main facilitators to employment that the professionals mentioned included advocacy, access to training, voluntary work and opportunities provided by supportive employers.

### Partnership working

Knowledge of the benefit system was limited amongst the professionals interviewed, as were any formal links with Jobcentre Plus or Department for Work and Pensions (DWP). However, they were keen to improve these links through training of staff in both drug agencies and Jobcentre Plus, specialist staff being placed in the partner agency, and co-location.

## 4.1 Characteristics of PDUs

Professionals described PDUs in their area as a marginalised group who experienced stigma and had complex needs. They explained that the clients they worked with often have a number of issues in their lives that explain their benefit uptake or act as barriers to employment, other than just their drug use. In particular, professionals described mental health issues as prevalent amongst their clients:

*'These are people who, there's a fair percentage who are depressed, which is probably 50 per cent, and they will be lacking in motivation. They are people who are emotionally, very often, disturbed. They are people who are living in penury.'*

Physical health problems were also mentioned by the same interviewee:

*'They're the only people I know who will go without food because they've got no money, and unlike the rest of my practice population which suffers obesity, I frequently get requests for build-up supplements which I refuse, and occasionally get requests for food. We keep a supply of food in order to give people, to tide them over.'*

The interaction of different problems was frequently mentioned by professionals when describing the characteristics of PDUs in their area. Interviewees speculated on the reasons for drug use and how this was linked to other problems in their clients' lives – and in turn how drug use exacerbated these problems or created new ones.

*'Drug use is usually a product of something, or exacerbated drug use is a product of something. [They've] got a whole host of other issues, whether that be housing, employment, family breakdown, it could be that they've got a health need that isn't being dealt with, for example, it could be that they've got chronic toothache because they've got chronic, rotten teeth and when they stop using the drugs, that pain is so unbearable that they start using again. Often it's things like that that we have to deal with.'*

*'Most people who have complex drug issues and are alcoholics, they have a lot of issues going on in their life. You'll find that they won't just be an alcoholic or drug user, they may have experienced abuse. They may have problems with their children; their children may be on the at-risk register. They may have problems with their housing because they're anti-social, or the neighbours don't like living next to them.'*

Professionals were asked whether they felt their clients were willing to acknowledge or disclose their drug use, particularly in order to access benefits but also other forms of support. Views were divided on this. Most interviewees felt that the drug users they encountered were willing to disclose their use.

*'I don't think the majority have a problem. You may get the minority who have a problem, maybe they're professional people who have entered through treatment service, through the NHS or a statutory agency. But the majority of people I've found, and I've worked in advocacy for ten years, I don't think there's many people that would mind. If they thought they could get their benefits quicker, they would gladly tell you anything.'*

Others pointed to a group who were unwilling to access treatment or other support and therefore, may be unlikely to reveal their drug use.

*'I think there's a group that wants to keep their drug use hidden. I also think there's a group of people who don't want treatment. So you've got two separate groups. Well, you've probably got more than two. Within the ethnic community, a lot of people there don't want to disclose, they don't want to disclose their drug use anyway because of the culture. There's other people who maybe, further up the social scale, who want to hide their drug use and alcohol use because they don't want anybody knowing because of their employment, because of what they do in life. Then you've got the other group of people that are out on the street that don't want treatment anyway.'*

There was consensus amongst interviewees that irrespective of the characteristics of particular PDUs, all were at risk of experiencing stigma. This stigma could contribute to lack of disclosure or discourage people from seeking help. It could also act as a barrier to moving out of drug use into training and employment, a theme we return to later.

*'Yes, there is a stigma. There's always been a stigma and always will be. It's even more stigmatised than mental health. But people won't say that. They won't admit it. Drug users in the community are very stigmatised because they rob and steal. Because they go around looking like, you know, whatever. They can't help that, it's part of their lifestyle.'*

*'I think there's always a stigma with an ex-drug user and I think that's something that we're going to have to break down, that stigma, and raise awareness. I think a lot of places have a ruling that they've got to be drug-free for two years, which does sort of hinder their rehabilitation because what makes you stable is drug treatment, and to be ready to move into work and if they are prevented from doing that they could go back to the drug use.'*

## 4.2 The benefit system

Professionals were asked a series of questions about the benefit system. In particular, interviews explored professionals' perceptions of how PDUs accessed benefits and the relationship between the benefit system and the professionals' role or that of the agency they worked for. A number of sub-themes emerged including:

- benefit receipt and drug use;
- which benefits PDUs access;
- barriers to benefit uptake;
- facilitators to benefit uptake.

### 4.2.1 Benefit receipt and drug use

Interviewees had mixed views regarding the extent to which the social security system helped or hindered PDUs' recovery. One interviewee, a GP who conducted medical assessments for IB, described the perverse incentives in the system in that clients were often keen to appear as 'disabled' as possible in order to gain access to a higher level of benefit. In contrast, other interviewees emphasised the importance of benefits as a safety net, providing an income that allowed PDUs to survive while using or while in treatment.

However, some interviewees pointed out that some of the drug users they had seen survived outside the benefit system because they either did not feel they qualified or did not bother to try to qualify because the income they needed for their drug use exceeded benefit levels.

*'In their own heads they don't think they qualify. They obviously can qualify, but getting the motivation to get down there, face somebody and be constructive in what they're trying to – they can't do it. Because most of them have been out for a long time. Long-term users, they can't be bothered with all that process. They just go out and rob something, shoplift it, that's the way it works.'*

*'If they're using three bags a day, say that's £60 a day, which is – you'd be lucky to use three bags a day with the quality round here. More like six bags a day, £120. So, you're looking at £850 a week. Where do you get that from? You go and steal it. Shoplift, rob, steal, lie, cheat, whatever. That's what our drug user does... They get it somehow. Or they go and sell their body on the street, if they're females.'*

This perception that some PDUs do not 'bother' to access benefits goes against the perception that most claim while using heroin or crack cocaine. It was a view expressed by many interviewees. All described the benefit system as complex to negotiate – and if the income obtained was too low to fund drug use, they were convinced that many would not claim. However, once users were in treatment or accessing other forms of support, the importance of benefits increased. Benefits were described as a central component of recovery from drug use.

#### **4.2.2 Which benefits PDUs access**

As described in our methods section, we were not able to interview Jobcentre staff as part of this study. However, we did ask the professionals that we interviewed about which social security benefits their clients accessed. Not all the professionals we interviewed were able to answer this question. However, some, including, in particular, a welfare rights worker whose job it was to help PDUs negotiate the benefit system, provided detailed responses.

According to the professional interviewees the most common benefits for PDUs in the study areas were IS and IB (at the time of the study). IB was mentioned frequently and a number of interviewees were aware that this benefit was in the process of being reformed – a theme we return to at the end of this section of our report.

*'Our stats on drug and alcohol, the biggest benefit enquiries are disability benefits and incapacity for work benefits, overwhelmingly. Related issues are Housing Benefit and Council Tax Benefit, Social Fund applications for grants and loans and some debt, but mostly it's been incapacity for work or disability benefits. It's not surprising, really, I don't think.'*

*'Most clients will say to me "I'm on Incapacity or Income Support". And they perhaps would be reviewed once a year and unless they're on a methadone script or some kind of specialist treatment, they tend to be seen by the benefits agency as shirkers, as people not really wanting to work and trying to trick the system. So their medical assessments up until now, I think the system's changed, were quite stressful for them because they didn't have, like, something wrong with their legs or their arms or their eyes or their ears, they were seen as being shirkers.'*

Other interviewees reported that some of their clients were accessing JSA and made attempts to comply with the requirements of that benefit, including signing-on and looking for work, while accessing treatment. Overall, it appeared that the type of benefit PDUs accessed was dependent on the other problems that they

could demonstrate, be those mental or physical health problems, in addition to substance misuse.

*'A lot of them are on Jobseeker's Allowance that are heroin users because they don't want to say "I can't work because of this". But if they've got mental health problems they probably involve the mental health services which means they would get Incapacity or Income Support or Disability Living Allowance because of that anyway, so then they would come in and do a diagnosis. A lot of the workers actually fill out the forms for people who've got mental health problems so that they might put the diagnosis of substance misuse on that; but if they aren't as severe as that, then Jobseeker's – there's such a cross-section it's so hard to say, there's such a cross-section of clients in different situations.'*

One of the problems highlighted by interviewees, however, was that some PDUs could fall between different benefits and find themselves with no income. The welfare rights worker who was interviewed explained that many of her clients were refused incapacity benefits on the basis that their main problem was drug or alcohol use and therefore they should be fit for work. She would support them to launch an appeal, but while that appeal was being processed some would transfer to JSA. Often these appeals would fail and the client would remain on JSA but be unable to comply with the requirements of that benefit in terms of being available to take up employment. The welfare reform process that was underway when this research was being completed is intended to deal with some of these issues. However, at the time of our study it was apparent that, in contrast to the perception that drug users may be abusing the benefit system, some were encountering considerable difficulties in accessing benefits.

#### **4.2.3 Barriers to benefit uptake**

Professionals identified a number of barriers to drug users accessing benefits or obtaining the right benefit for their circumstances. Some of these barriers were the same as those identified by PDUs earlier in this report, including procedural barriers around form-filling or attending appointments. Others were similar to those articulated by PDUs but were expressed in a different way by professionals. Thus clients talked about communication or relationship difficulties with Jobcentre Plus staff, while professionals placed this within the context of a mismatch between the behaviour and expectations of their clients compared with Jobcentre Plus staff. In contrast to PDUs, professionals also discussed facilitators to accessing benefits, most notably the role of support or advocacy in negotiating the benefit system.

Professionals talked in detail about how the behaviour of their clients could make accessing benefits difficult.

*'They can become quite angry and frustrated, so it's not productive. They lose their temper and then they're asked to leave. Others are still on drugs, high medication, if they're on say, about 125mg of methadone, or they're still using drugs, you can't expect a drug user to be able to understand any system because they're just not with it.'*



Individuals who are still using drugs may not manage to access the benefits that they are entitled to, either because their lives are too chaotic or the system is too complex for them to deal with. Professionals also pointed out that the social security system was not structured to deal with unusual behaviour, such as that which PDUs might display.

*'Many of them – and I don't know the percentage of this – but I would say approaching 25, 30 per cent have got no fixed abode and they can be smelly. I think that from the benefits agency's point of view, if I was a middle-class person sitting behind the window in the benefits office I would find this group very, very difficult. I think that where you have vulnerable people you need to establish relationships in order to get some understanding of the person and to be able to help them. Within the benefits agency it's seen as a purely mechanical transaction if you can feed things into a computer, and your giro comes out the other end; whereas with this group of people it needs to be more human, more subtle, more understanding than the current situation allows.'*

The welfare rights professional who was interviewed highlighted some of the challenges she faced in encouraging PDUs to turn up to appointments so that she can assist them with their benefit claims.

*'People do turn up, but often you'll be told there's three or four people who need to see you and only one turns up. Sometimes other people turn up because they operate on a drop-in basis, so the client you might have expected to see won't be there but someone else might be. We try to have appointments because we want to have some kind of idea who we're going to see and what it's about, but it doesn't always work terribly well.'*

Interviewees discussed some of the procedural barriers to accessing benefits, similar to those raised by clients. They discussed the effort and persistence required to initiate a claim, and then the intricacies of the appeal process. They discussed language and literacy as well as entitlement (i.e. for non-EU nationals with drug problems). They highlighted how the sometimes chaotic lifestyle of PDUs, even those accessing treatment, often involving problems with housing and therefore, greater difficulty with regard to receiving and responding to correspondence, all made claiming difficult.

Many of the professionals we interviewed were in jobs that involved acting as advocates for adults with drug misuse problems. Their roles included assisting drug users with benefit claims, helping them to find housing, assisting with family problems or issues, attending appointments with them (including in the criminal justice system in some cases) and arranging training or volunteer work. Perhaps not surprisingly given the discussion above, these interviewees saw the advocacy element of their role as very important. The welfare rights officer we interviewed, for example, emphasised the complexity of the benefit system and described how, without her intervention and support, her clients would not be able to access the correct benefit. Thus, advocacy was listed as an important facilitator to benefit uptake.

### 4.3 Treatment

Professionals were asked about drug treatment services in their area and, in particular, their views on the links between treatment, recovery and employment for PDUs. Interviewees commented on who accessed treatment, the nature of that treatment, and treatment as part of the pathway to work.

In all five case study areas treatment services were available to PDUs and all our interviewees either worked in these services or had strong links to them. Interviewees pointed out that the existence of such services did not mean that drug users would necessarily access them, and that the decision to enter treatment is a highly personal one that cannot easily be influenced by professionals. As one interviewee said:

*'My conception is that some are just...they're not ready for it. They're not ready to stop using, they're not ready to look at the harm minimisation side of things, they're just not ready.'*

Interviewees acknowledged that those willing to enter treatment could face a delay in being able to access it, although this was not identified as a wide-scale issue in any of our case study sites:

*'In some areas, although not specifically xxxx, but waiting times do affect that, in different areas. In xxxx we're very lucky, apart from the prescribing side of things, we've got our waiting times down to about, maximum three weeks, which is in accordance with the NTA. But a lot of people don't go into treatment – there's a group of people who don't go in treatment because of the waiting times, specific things in other areas. If you've got to wait, say, six months, to get into treatment, and you've got no money to go into private treatment, or your motivation goes and you're not ready, then the opportunity is lost.'*

In thinking about treatment as part of a pathway to work, interviewees emphasised the fact that most of the clients they saw could be in and out of treatment over a number of years. They also commented on the time it takes for PDUs to recover and highlighted that returning to work would not happen quickly for most clients.

*'The course of treatment, it starts with detox, which can take two to three weeks. It can take longer for some people, there's also residential detox which can take longer. Then there's the treatment programme which is 12 weeks, then you've got your after-care. So to even think about getting people back to work in the first six months, the majority of cases, most people need a good six months before they can even start thinking about work.'*

*'In my experience over the last 16 or 17 years, I've seen a lot of people go into treatment. I've seen a lot of people go through it five or six times. One in a thousand gets it first time. I think you need to be realistic about that. However, the other side of the coin is that I've seen many people, I know at least, probably, 50 people, in the last ten years that have successfully completed treatment. They've come through the treatment process and they're now in full-time work. So treatment does work, but it doesn't work as quick as the government wants it to work.'*

For those who successfully complete treatment, interviewees emphasised the importance of activities such as training and voluntary work as stepping stones to paid employment. They also described the importance of mentoring or advocacy in helping PDUs make that transition.

*'I don't think there are services to meet the needs of certain people. I think there's the need for more mentoring support and a lot of softer support, more long-term. I mean there's lots of drug treatment and people access that as part of ending their drug-use, but we get clients that are nowhere near the labour market and need more mentoring or possibly over a longer period and that isn't available, so more people get lost.'*

## 4.4 Employment

Interviewees discussed the extent to which PDUs in their area accessed employment opportunities and also explored in detail some of the barriers and facilitators to moving into (or back into) the labour market following drug treatment.

### 4.4.1 Employment opportunities

The professionals interviewed emphasised that the vast majority of the drug users they encountered (who, due to the roles of those we interviewed, were primarily engaged in treatment) were unemployed. As the GP we spoke to stated:

*'We have about 150 or 160 patients and I would be surprised if many more than ten are in legitimate full-time gainful employment, and another ten or maybe a few more are in black employment, if you like, doing bits and pieces here for cash in hand.'*

Those interviewees who had contact with PDUs who were employed explained that most of the employment available in the area was short-term and low paid, often manual or service work. Despite this, interviewees emphasised the benefits of any form of employment to PDUs.

*'It gives them more motivation, it gives them more confidence, it gives them more self-respect and self-esteem, puts more money in their pockets so that they can care for other people that little bit better, and it means that they can live their life more fully within their families.'*

*'Getting a job is good for your mental health. Just getting out there, doing something. Whether it's a paid job or a voluntary job, it doesn't matter, because you're out there doing something. You're not bored, sat at home, like you used to be with your drug use. So it's healthy to get a job.'*

Making the transition to work is challenging for those with a history of drug misuse, as the interviews with clients illustrate. Professionals discussed in some detail a range of barriers to work in their area.

#### **4.4.2 Barriers to employment**

A number of factors can prevent PDUs from returning to work, even following a successful period of treatment. The issues that professionals identified were similar to those articulated by drug users themselves, and also reflect the dominant themes drawn out in the literature review. They include:

- time out of the labour market;
- a 'culture' of unemployment in some communities;
- mental health issues;
- medication;
- criminal records;
- employer attitudes.

Many adults with drug misuse problems, particularly those who have used drugs such as heroin or crack cocaine, have either never worked or have limited work experience. Even those with experience may have had long periods out of work due to their drug use. As one interviewee explained:

*'It depends how long they've been out there. If they've been out there for 10/15 years, which some drug users have, then all the qualifications they had then are out of date. Then you've got to retrain. So it's not as easy as just going back to what you used to be doing, because, I don't know many drug users who could do that anyway, to be honest. If they haven't had any qualifications and they come out of school then they've got to go to college and be retrained and they don't really like doing that if they can get out of it. They'd rather get a job somewhere else...and then, in the current climate, for jobs, it's rubbish anyway.'*

A related issue was that of PDUs' expectations regarding work. As previous sections of this report have emphasised, drug use is linked to poverty and a range of wider social problems, and some drug users have grown up in communities where unemployment is common. For these PDUs, entering the labour market is not necessarily a natural next step following treatment.

*'I've worked with some clients who've never worked. Never. I mean, it's just amazing. You can't even think about it, but there are people in poorer sections of xxxx who have never worked. Their fathers and mothers never worked. They were on benefits.'*

For professionals working with these clients, a number of other forms of support and encouragement were required to overcome low expectations regarding jobs, before seeking employment was possible:

*'If you've been using crack or heroin for many years, you find it quite difficult to get on with people. It's quite hard. So what we're saying is we want environments like volunteering, like mentoring, like training and education to widen people's horizons and not just pushing people into jobs.'*

Others emphasised that mental health problems amongst PDUs can act as a significant barrier to employment. As the literature review section of this report highlighted, a dual diagnosis of substance misuse and mental health problems is not uncommon and, for these individuals, the transition from treatment to employment cannot take place without their mental health needs being addressed.

Likewise, leaving treatment does not necessarily mean that individuals are drug-free and those on methadone maintenance programmes may face a number of barriers to finding or staying in work. Some of these barriers relate to their capacity to work on higher doses of methadone, while others relate to the need to regularly access their medication which may not be compatible with certain forms of employment.

*'There are a range of barriers that our clients face to move into work and I think this is one, it's the medication. Obviously certain types of medication stop people from doing certain types of jobs...or they have to take time out of work to ensure that they can pick up their medication, so yeah; I think we need to raise employer awareness there.'*

Equally important, previous criminal convictions preclude drug users from accessing some types of jobs. This was an issue raised by a number of the professionals we interviewed.

*'When you're on drugs...not always, but, you do bad things. You can do bad things to score. You know, you leave your children alone to score. You commit acts of violence and that has been a big problem, because, you know, if an employer sees that, outside the drug and alcohol world, they're going to go "I don't know whether I want this person to be working with me. What kind of person would they be? They've been inside for GBH, and they're very violent, so that has been a big problem".'*

*'When she does her CV she doesn't want to put that she was a street-worker. So there's a gap and sometimes it can be difficult for people...you want to keep it private and emotionally it's degrading and she doesn't want to tell people that she's done that but she physically wasn't able to work because of the fact that she used crack cocaine for so long it had actually impacted on her physical health. She was genuinely trying to help herself but she was coming up against these barriers.'*

Finally, interviewees described at length their experience of the negative attitudes of many local employers towards ex-drug users. These attitudes were often linked to issues around continued methadone use or criminal records as described above.

*'Probably because of the nature of the illness is that people can be well for a very long time, just like mental illness, but then can relapse and become very unwell and that's quite difficult for an employer to accept. If you've got a back problem, the employer can kind of accept that, that's a physical condition, but if you, you know, fall off the wagon and come into work drunk, it's really unacceptable.'*

Because of these attitudes, some drug users leaving treatment aim to conceal their drug-using history from employers. This issue of disclosure was mentioned by a number of interviewees – both disclosure of drug use to benefit agencies, as highlighted earlier, and to employers. Professionals working with drug users felt that employer attitudes needed to change and that greater public education about and understanding of drug use would facilitate this change. They also felt that government programmes and incentives for employers to employ adults leaving treatment would make a difference.

#### **4.4.3 Facilitators to employment**

The main facilitators to employment identified by the professionals we interviewed included advocacy, access to training, voluntary work, and opportunities provided by supportive employers. We address each of these issues in turn.

As outlined in the section on benefits above, many of the professionals we interviewed had an advocacy or 'buddying' element to their role. This involved providing a range of support to drug users in or leaving treatment, including assisting clients to move back into work:

*'I believe that people need more practical support rather than "let's get you a suit". Okay, so, you're going for interview. It's on such a day. Would it be worthwhile if I came to see you an hour before and we did some interview techniques and I actually take you to the interview and meet you afterwards. I think that buddying is more beneficial than "here's £50 worth of vouchers and we'll get you some work boots and a high visibility jacket" and all that kind of stuff. Because a lot of our clients find the bit of getting from A to B difficult – it's practicalities.'*

As also outlined previously, interviewees also described how PDUs who had been out of the labour market for some time, or who had never worked, need access to training opportunities before even contemplating employment. Training, and funding for training, was repeatedly mentioned as part of the pathway to work. Interviewees talked about training as a first step back into employment.

*'I'm a big believer in saying "well, what are you wanting to do? Do you expect the state to pay for that for the rest of your days? Haven't you got any sense of pride and responsibility?" often a lot of people do and they absolutely want to work and we can say "well, have you thought about doing any courses". It's a good opportunity for a lot of people, while they're in recovery, to do some of these courses, because it's short, sharp shocks, if you like, that gets them ready for the world of work.'*

Others discussed the need for more basic skills training.

*'I would say roughly 80 per cent of our clients haven't completed school and have some sort of illiteracy or innumeracy needs, so that's a massive gap that we aim to plug and try and encourage people to do adult education and get qualifications.'*

Several interviewees employed by treatment agencies described how they could use their treatment budget to provide funding for some clients to access courses. They described courses that would yield national vocational training qualifications (National Vocational Qualifications (NVQs), often Level 2) as something they would encourage clients to undertake while in treatment. In many instances this training was in the drug or alcohol field with a view to the individual finding future employment in this area. At least one of our interviewees was a former drug user, now employed as a service user advocate, and he outlined how this type of training had helped in his recovery.

A natural next step following on from training is voluntary work. Volunteering was described as valuable in its own right – and available for PDUs in most areas – but particularly useful for preparing clients for the routine of getting ready for, and going to, work.

*'If people are on benefits, and they're deemed fit for work, they should be getting involved in community ventures. Especially our client group because that would really help them get ready for work.'*

*'Trying to encourage people to do voluntary work has been another way we move people towards the jobs market. Developing those skills, building their confidence and enabling them to do references and building a reputation for themselves. We look at work trials and try to encourage them to use work trials and job placements and then we'll provide in-work support once people have found work.'*

Some voluntary work, particularly formal placements, requires an application process and interviewees described how they have supported clients to complete these applications. In some cases voluntary schemes required PDUs to have been drug-free for a specific period of time, usually two years. Interviewees described this requirement as a barrier to progress for some clients but as necessary for others.

Finally, examples of supportive employers were provided – local agencies who accepted adults who had left drug treatment as employees and had appropriate policies and procedures in place, including links with treatment agencies and advocates to support employees. These were described as few and far between in each case study area, and always included drug and alcohol agencies. However, some other organisations were provided as examples and interviewees expressed some optimism that current efforts to improve the links between treatment agencies and employers would improve attitudes and therefore job opportunities for recovering PDUs.

## 4.5 Partnership working

Current reforms to the welfare system are aimed, at least in part, at encouraging greater inter-agency working to meet the needs of PDUs and other groups, including adults with alcohol misuse problems. Thus interviewees were asked what links their organisation – primarily Drug Action Teams (DATs) or voluntary sector treatment or user support agencies – had with their local Jobcentre Plus, the DWP or other organisations with an employment focus. Interviewees discussed the extent of current links and how these could be improved.

Amongst the professionals we interviewed, there was limited knowledge of the social security system or formal links with the DWP/Jobcentre Plus. The exception was the welfare rights officer we spoke to, whose role involved supporting clients to access benefits. More common responses to the question – do you have any links with your local Jobcentre Plus – were:

*'No, we haven't. I think traditionally drug and alcohol services have been seen as separate from lots of other services, not just the DWP, from social services, so we would find that clients who had childcare issues, it was never discussed with the drug and alcohol agency. But we are starting to develop links because we know that there's going to be a move towards this thing of what people can do rather than what they can't do and we need to build those links.'*

*'I would love the staff to be more au fait with what's going on locally in terms of Jobcentre Plus, because I would hate to think we ended up giving the wrong advice. I think the jobcentre should retain it's element of expertise and we should retain ours. And hopefully share the future of services that will meet the needs of our client group.'*



*'We don't tend to receive many referrals from Jobcentre Plus. It's something we're trying to build on within the group at the moment. There's just been a Jobcentre Plus co-ordinator come into the post. I'm certainly hoping to make contact with him but at the moment I wouldn't say we have very strong links with Jobcentre Plus at the moment.'*

Thus existing links between drug agencies and Jobcentre Plus were poor, but most interviewees were aware of current reforms and keen to make stronger connections. When asked how links could be improved, interviewees discussed training for staff in each agency, specialist staff being placed in the partner agency, and co-location.

On the issue of training or knowledge-raising, interviewees felt that Jobcentre Plus staff should receive training in dealing with clients with drug and alcohol problems – although some acknowledged that this training may already be in place. In turn interviewees expressed a need for more information in some cases about benefits or who to speak to in their local Jobcentre. They pointed out that systems and processes in both the drug and alcohol field and in social security had changed and were changing, and that if more training and information was to become available this would need to be regularly updated.

Interviewees were positive about the move towards placing staff with expertise in drug and alcohol services into Jobcentres. They could also see a place for Jobcentre staff on their local DAT partnership. Finally, interviewees described how being located in the same building with colleagues with an employment or welfare rights remit worked well and that this could improve the links between drug treatment and support for PDUs to return to work.

*'Because we're in there, we can pull up and say "oh, hi, I'm from xxxx" and the other workers are there saying "I need to talk to you about this" or, we get a lot of what we call second tier requests for information, so, the actual support worker will say "what should I be saying to him about this?" or "where should I send him?" or, you know, or "is he on the right benefit. I'm not sure this is correct", you know, that kind of enquiry. So, there's a lot of exchange, mutual exchange of information.'*

*'I can't imagine anywhere else in the country sharing an office with xxx...it is a national organisation, part of jobcentre, and they help people get to work and they literally sit behind me. I can hear them talking about clients and I'll say "No! No! They're not getting your letters" and vice versa, and we do have a very good relationship and we also work with the NHS as well who actually refer the clients to us so we all work in the same office, so we just literally walk across and say, you know, "this person's in this situation: what can we do?"...it works well.'*

## 5 Conclusion

This report examined the issue of benefit uptake amongst problem drug users (PDUs) in England through a review of relevant literature and interviews with drug users and professionals working in the drug treatment area. In trying to address the study aims, we found that a much wider range of issues than just the benefit system needed to be explored. We found that gaining some understanding of the relationship between an individual's drug use, their background and health, their education and employment history and their experience of treatment was necessary. In completing this study, therefore, we found ourselves examining a very broad body of literature and exploring a wide range of themes with our interviewees. However, in revisiting the original aims of our research, three main areas for discussion arise. The first relates to the profile of PDUs and how some knowledge of this is necessary to understand their place in the social security system. The second is PDUs' experiences of accessing benefits. The third and final area for discussion is how PDUs make the transition from benefits to employment.

### 5.1 The profile of problem drug users

This study contributes to current understanding of the profile of opiate and crack cocaine users in the UK in two ways. First, it summarises what we know from the literature about drug users in terms of demographic characteristics, health, education and family issues. It also highlights the needs and experiences of a particular group of PDUs who agreed to participate in this study and were recruited through treatment agencies. It is worth commenting on both these sources of information and exploring any differences between the two.

The UK and European literature on problem drug use suggests that most PDUs are male and that this type of drug use is most prevalent among individuals in their 20s and 30s (March *et al.*, 2006, Payne-James *et al.*, 2005, Puigdollers *et al.*, 2004). Our interviewees were also predominantly male but were slightly older, in their 30s and 40s. This probably reflects life course issues with individuals accessing treatment following a history of drug use. Our interviewees talked about escalating drug use – and the transition from cannabis and alcohol use to harder

drugs – as a gradual process and also described how they had entered treatment after using for a number of years.

Although our interviewees had a wide range of life experiences and came from a range of backgrounds, they did share a number of other characteristics that are similar to those described in the literature. None of our sample discussed owning their own home, and some had been homeless in the past. Problems with housing and homelessness are common in studies of drug-using populations, with one Scottish study, for example, finding that over a third of heroin users were homeless at one or both interview points over an eight-month period (Kemp *et al.*, 2006). Likewise our sample had poor educational attainment, with most leaving school at or before the age of 16. Low education levels have been found in surveys of drug users in the UK and overseas (Puigdollers *et al.*, 2004; Luck *et al.*, 2004). When asked about their childhood, a number of our interviewees described being in care, and also discussed how their experiences of care homes and foster care had contributed to their drug use. Although we identified very little UK literature on this issue, one British study found that drug use was much more common amongst care leavers than others (Ward *et al.*, 1998).

Mental and physical health problems affect a significant proportion of PDUs. The literature we reviewed identified a number of concurrent physical health problems, particularly among long-term drug users (Hser *et al.*, 2004). These problems can include higher rates of hepatitis C, HIV/AIDS and physical impairments that can affect PDUs' ability to complete everyday tasks and therefore, to work (Neale, 2001; Kemp and Neale, 2005; March *et al.*, 2006; Payne-James *et al.*, 2005). The professionals we interviewed, including one GP, also discussed the prevalence of physical health problems amongst their clients. The PDUs we interviewed described their own health issues, primarily linked to their drug use, and reported problems with deep vein thrombosis (DVT) and hepatitis C, for example.

The prevalence of a range of mental health problems amongst PDUs is well documented and our literature review summarises findings from a number of UK and international studies on this issue. The professionals we interviewed mentioned behavioural problems amongst their clients that may have been linked to mental health problems. However, we were unable to explore this issue in detail with the PDUs in our study. Some reported problems with depression, or in one instance, psychosis, and described how this affected their experience of the benefit system and readiness for work. However, interviewees did not discuss their mental health in any detail and we were not able to explore this issue in depth with them. It is also highly likely that our sample may not have been representative of all PDUs in this respect. Because they were recruited through treatment agencies, all had accessed treatment and it is possible that PDUs with a dual diagnosis are less likely to seek or be able to access appropriate support. Our study respondents were also referred to us by treatment agency staff, who may well have approached clients

whom they felt would be able to engage in a detailed interview. This process may have excluded some PDUs with mental health problems.

It is apparent from the literature and from the accounts of our interviewees that the needs and circumstances of PDUs in the UK are varied. Overall, they are a marginalised group, many of whom (although not all) have experienced disadvantage from an early age. Their drug use arises at least in part from wider problems in their lives, and then serves to create further problems such as physical and mental health issues. It is with this background of complex needs that PDUs then encounter the benefit system, which brings with it further challenges.

## 5.2 PDUs and the benefit system

Our previous research found that PDUs account for almost seven per cent of the working age population on benefits in England, while they make up only one per cent of the working age population overall (Hay and Bauld, 2008). The reasons for this over-representation of PDUs in the benefit system is something the current study set out to explore. However, at the time we did our literature search, there were no other UK studies that examined this issue in any depth. Our findings, therefore, on PDUs and the benefit system focus largely on information gathered from our interviews, with reference to a limited body of literature from the USA that can only be applied to the UK context with caution.

In our interviews with drug users and professionals we aimed to explore in some detail which benefits were accessed and how patterns of benefit uptake might have changed through time. Amongst our sample of PDUs the majority were currently accessing benefits, the most common of which were Income Support (IS), Incapacity Benefit (IB) and Jobseeker's Allowance (JSA).

The drug users we interviewed outlined a number of barriers to benefit uptake, and these were echoed by professionals although described in different ways. PDUs, like many unemployed adults, expressed confusion regarding the benefit system and frustration about the lack of available advice. They provided a number of examples of poor communication with local Jobcentre Plus staff and with Department for Work and Pensions (DWP) staff over the telephone. Professionals described problems with some PDUs' appearance and attitude that Jobcentre Plus staff might find difficult to deal with. These findings echo those of Henderson and colleagues in the USA, who interviewed welfare agency workers and found that, in their view, adults with substance misuse problems require more intensive, personalised attention than most workers were able to provide (Henderson *et al.*, 2006).

The PDUs we interviewed also reported that they felt stigmatised by Jobcentre Plus staff, particularly once their status as a drug user had been disclosed or was known. Again, this echoes findings from American studies (Luck *et al.*, 2004). Finally, a range of procedural and process issues were highlighted as barriers to benefit uptake including problems with moving from one benefit to another, more appropriate benefit for PDUs with health problems (eg. JSA to IB). PDUs reported

problems in completing application forms, attending appointments, in submitting claims and appeals and confusion regarding eligibility criteria. Some reported losing eligibility for benefits and the fear that no access to income from benefits would drive them back into drug misuse, even after a period of recovery. Professionals also identified similar problems, but suggested that wider availability of advocacy for PDUs could help remove some of the barriers. Advocates employed by treatment agencies to help users to access benefits and other forms of support, or welfare rights staff with good links to drug agencies, were described as extremely helpful. However, the availability of these staff was limited in our case study areas.

### 5.3 The transition from benefits to employment

Our research explored the problems and barriers that PDUs face when they try to make the transition from benefits and treatment to paid employment, or where that is not possible, to training or voluntary work. In particular, we examined whether PDUs were employed, the barriers to employment, the role of treatment in helping PDUs move off benefits, and views about welfare reform.

Other studies have found that users of 'hard' drugs such as heroin and crack cocaine are significantly less likely to be in employment than other adults of working age (MacDonald and Pudney, 2001, 2002). Research has also found that duration of unemployment is associated with the number of drugs an individual has used (Plant and Plant, 1986). In our study, few interviewees were in employment at the time we spoke to them, and all had experienced unemployment at some point in the past. The most commonly cited reason for leaving their last job was because of drug use, including being dismissed because of their behaviour or when their drug use was discovered. In the literature and amongst interviewees, the type of jobs that drug users held were largely low skilled positions (with some exceptions) and often temporary. Most interviewees had been involved in cash-in-hand employment at some point in their lives, illustrating some of the problems associated with finding legal employment for this group.

Sutton and colleagues conducted a review of the literature examining barriers to employment for adults with drug and alcohol problems that was published in 2004 (Sutton *et al.*, 2004). They identified six major areas of disadvantage that acted as barriers to work including: lack of education and skills; health; social disadvantage; provision of support services; engaging with employers and support professionals; and dealing with stigma. The clients and professionals we interviewed mentioned all these barriers, and other recent research conducted by the UK Drug Policy Commission (UKDPC) has examined similar issues (UKDPC, 2008). Taken together, these studies suggest that PDUs face considerable challenges in making the transition to work.

In addition to the main barriers highlighted by Sutton and colleagues, we also found that mental health problems and involvement in crime were significant issues. When asked about how they felt about returning to work, the PDUs we interviewed said that lack of confidence was the most significant problem they

faced. In some instances they attributed this lack of confidence to their mental health. The literature we reviewed highlighted that mental health problems can make returning to the labour market difficult or impossible for adults with substance misuse problems (Zabkiewicz and Schmidt, 2007; Marwaha *et al.*, 2007). Likewise a significant proportion of our interviewees had a criminal record, with a number reporting short spells in prison and a minority reporting that they had been in and out of prison for the majority of their adult lives. PDUs reported engaging in shoplifting, fraud and burglary and in some cases violent crime. One interviewee acknowledged that she was still working as a prostitute two days a week despite being in recovery and accessing benefits. The links between criminal behaviour and drug use are clear from the literature, as are the consequences in terms of employers' unwillingness to take on those with criminal records (Kemp *et al.*, 2004; Payne-James *et al.*, 2005; UKDPC, 2008).

Our study found that there was a number of facilitators to future employment for PDUs. The most significant was receiving and completing a course of drug treatment. Following on from, and linked to, that we also found that training and volunteer work were crucial stepping stones to work. Finally, support to find work and other opportunities, from drug and alcohol workers and Jobcentre Plus staff, was important.

## 5.4 Welfare reform

We touched indirectly on the issue of welfare reform in this study; in the context of the changes introduced in the 2009 Welfare Reform Act following the green paper *No one written off: reforming welfare to reward responsibility* (DWP, 2008). One element of these reforms, the Welfare Reform Drug Recovery Pilots, is being piloted in five areas across England from October 2010. It involves a new Additional Support programme which, on a voluntary basis, will provide integrated and personalised support for JSA and Employment and Support Allowance (ESA) claimants who are undergoing drug treatment. A Treatment Allowance for PDUs who are in treatment, in place of their ESA or JSA, will be payable on a voluntary basis to the individual as long as they maintain their treatment and engage with the Additional Support programme. In addition, some of the normal conditions of entitlement for benefit will be removed in order to allow drug users the time and space to focus on their recovery. For example, this will mean that those on JSA will not be required to sign on or show that they are actively seeking work. PDUs who are in receipt of JSA and ESA and not ready to go into treatment will be required to attend a Substance Related Assessment with a drug treatment advisor and then a Treatment Awareness Programme for six weeks.

Other countries have introduced similar changes in the past, and a literature on welfare reform and its impact on drug users does exist, primarily from the USA. American studies on the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) reforms of the mid-1990s, although not directly comparable, do suggest that welfare recipients who accessed treatment were more likely to find employment, that clients in government-funded treatment

did reduce their drug use, and that fears regarding longer-term, negative outcomes from introducing these reforms were largely unfounded (Montoya and Atkinson, 2002). However, in the short-term at least, drug users in the USA who lost entitlement to benefits through not complying with the new regime were more likely to return to drug-related crime to fund their drug use (Montoya and Atkinson, 2002; Swartz *et al.*, 2004).

Both clients and professionals interviewed in this study were in agreement on the need for closer working between drug and alcohol agencies, Jobcentre Plus and employers. Professionals described few existing links with Jobcentre Plus, but pointed out that these were expanding. Research evidence suggests that programmes that combine drug treatment with training and employment interventions do work, and that drug users are supportive of these kinds of initiatives (Kidorf *et al.*, 2004; Sutton *et al.*, 2004). The drug users we interviewed expressed a desire to return to, or remain in, work, but for all of them, the immediate priority was recovery. Only by becoming drug-free could they contemplate a future that included employment. As one interviewee put it *'I just want to get off it and be normal again'*.

## 5.5 Summary

Our findings illustrate the complex needs of PDUs and some of the challenges they face in their everyday lives. All the PDUs in our study had experience of the benefit system and had accessed different forms of benefits, primarily IS, JSA and IB. Many had encountered a number of problems in accessing the correct benefit to meet their needs and in finding the right type of support and advice. The professionals we interviewed, who primarily worked for drug and alcohol agencies, also described existing problems with welfare receipt amongst PDUs and made suggestions about how this could be changed and how current reforms may contribute to a better system in the future. All of the clients we interviewed had received treatment for their drug use and prioritised their recovery over other longer-term aims, including returning to work. However, while very few were in paid employment at the time of the study, almost all aspired to move back into some form of work in the future and described some of the forms of support, including access to training and volunteer work, that would assist in that process.

This study highlights the need for greater integration between drug treatment services, the social security system, employment services and employers. This, combined with wider availability of support to PDUs, will improve outcomes for this group. Current welfare reforms should help to make a difference, and a key priority for future research should be the evaluation of these reforms. Research should examine the extent to which these reforms have reduced the proportion of PDUs on benefits, increased treatment uptake and improved wider opportunities, including employment, for this group, now and in the future.

# Appendix

## Interview topic guides

### Drug users' topic guide

This interview will be conducted face to face and will begin with the interviewer reviewing whether the interviewee meets the study inclusion criteria (past or previous opiate and/or crack cocaine use, our sample must be >75 per cent current drugs users). If so, the interviewer will then explain the study to the interviewee, providing a study information sheet and obtaining signed consent. The interview will be semi-structured and conducted as a 'conversation'. General themes and specific issues for discussion ('probing') are therefore described here rather than a list of pre-defined questions.

#### **1 Interviewee profile**

A small amount of socio-demographic data will be collected from each research participant at the start of the interview including age, gender, housing and employment status and caring responsibilities.

#### **2 Education and employment history**

The interviewee will be asked to describe their experience of education including where they attended school, how long they attended, any difficulties they experienced and where they were living (with parents, other family members, looked after and accommodated etc) when they were attending school.

The interviewer will then ask about any experience of further or higher education and qualifications obtained, as well as any experience of other training courses or programmes.

Employment following education will then be discussed where relevant, including asking in some detail about the interviewees last job and reasons for leaving the job.



### **3 Drug use history**

Interviewees will then be asked to describe their previous and current use of drugs including alcohol and tobacco use (a drugs checklist will be used) and their perceptions regarding when their drug use became a problem and their experience of treatment to date.

### **4 Benefits history**

This part of the interview will focus on the drug users' experience of the benefit system, which benefits they have accessed in the past (a checklist of all benefits will be used). A particular focus will be on the transition between an employment-seeking related benefit (such as Jobseeker's Allowance) and a disability or incapacity benefit, where relevant.

### **5 Current benefits**

Interviewees will be asked about the benefits they currently receive (a checklist will be used) and the interviewer will probe the reasons why the drug user receives these benefits, including who suggested they may be eligible for each benefit.

### **6 Barriers to benefit uptake**

Any perceived problems or issues relating to benefit uptake will be explored with the interviewee.

### **7 Barriers to employment**

Interviewees will be asked about current and previous barriers to them entering or remaining in employment. Drug use will be addressed but other potential barriers that will be probed include:

- physical health (including hepatitis C);
- mental health;
- willingness to work (attitudes towards work);
- transport;
- stigma;
- obtaining references;
- lack of driving license;
- criminal records check;
- general presentation;
- lack of confidence;
- affordable childcare.

## **8 The informal economy**

This part of the interview will ask about drug users' experience of 'alternative' forms of employment and contact with the criminal justice system including where do they get income from, such as:

- working cash in hand;
- money from drug dealing;
- money from selling sex;
- money from shoplifting/theft/selling stolen goods.

Whether they have financial difficulties in general, recent contact with the criminal justice system.

## **9 Support services**

Interviewees will be asked about other support services they are in contact with and their perceptions regarding the role of that support in maintaining their participation in treatment and/or current or future attempts to enter employment.

## **10 Aspirations**

This final part of the interview will focus on the drug users' aspirations for the future. Specific issues to be explored include:

- becoming drug-free;
- becoming stable (on drugs/substitute prescription);
- employment aspirations;
- what is more important – sorting out drugs or sorting out employment?
- did the lack of job cause drug misuse from the interviewees' perspective or did drugs cause the lack of employment or were both because of something else?

## **Professionals' topic guide**

- Interviewee's role.
- Place of employment and benefit system in drug treatment.
- The process of benefit receipt for those who may be using drugs (asking the interviewee to talk us through the normal process as they understand it).
- Whether the interviewee has received any training or support to deal with training or employment issues.
- Perceptions of employability of those in drug treatment.
- Perceptions of employment opportunities in the local area.
- Links with job centres/training providers locally.

- Referral pathways to other relevant support agencies.
- Other types of links with other relevant agencies.
- Views on how the current system could be improved.

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This report presents the findings of a study commissioned by the Department for Work and Pensions (DWP) to examine the issues surrounding employment and benefit uptake in England by individuals who use illicit drugs, in particular heroin and crack cocaine. In addressing these issues, the study also explores the wider context of education, training, drug use and treatment.

This report has two key elements: a review of the literature on drug use and benefit uptake, and a qualitative component that included face-to-face interviews with 75 drug users and ten professionals who work with drug users to explore specific issues in detail. The research was carried out by a team from the Centre for Drug Misuse Research at the University of Glasgow and the Centre for the Analysis of Social Policy at the University of Bath.

If you would like to know more about DWP research, please contact:  
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